
TRICARE Program Management Office

Users' Guide

Version 2.1

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SECTION 1

TRICARE Program Management: An Overview

- ❖ *TRICARE Management Activity Mission*
- ❖ *TRICARE and Program Management*
- ❖ *Program Management Office Scope*
- ❖ *Program Management Office Structure*
- ❖ *Program Management Office Roles and Responsibilities*

1.1 TRICARE Management Activity Mission

The mission of TRICARE Management Activity (TMA) is to manage TRICARE; manage and execute the Defense Health Program (DHP) Appropriation and the Department of Defense (DoD) Unified Medical Program; and support the Uniformed Services in implementation of the TRICARE program and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE provides comprehensive healthcare for active duty personnel, qualified family members, TRICARE-eligible retirees and their family members, and survivors of the uniformed services. The TRICARE Program is designed to:

- Offer beneficiaries a choice of healthcare delivery options that meet their unique situations;
- Complement healthcare services provided by the Military Treatment Facilities and Clinics;
- Expand access to care;
- Assure high quality standards of care;
- Control healthcare costs;
- Improve the readiness status for military personnel.

The Assistant Secretary of Defense for Health Affairs under the Under Secretary of Defense for Personnel and Readiness exercises authority, direction, and control over all DoD medical and dental personnel, facilities, programs, funding, and other resources within the Department of Defense.

1.2 TRICARE and Program Management

The Director, Defense Procurement recommended that the principles of Program Management, as found in the DoD 5000 series, serve as a basis for managing major TRICARE acquisitions. To meet that end, a Program Management Office (PMO) was established to develop a centralized business approach using concepts from the DoD 5000 series. The PMO is now under the direction of the Deputy Executive Director, TMA. This centralized approach is used to manage not only healthcare contract acquisitions, but to also manage other complex TRICARE projects, reengineering efforts and demonstrations. The TRICARE Program Management structure outlined in this User's Guide:

- Creates clear lines of accountability and responsibility;

- Provides common structure and disciplined processes that can be used for all projects, and/or demonstrations;
- Provides the ability to tailor projects and demonstrations with unique characteristics;
- Identifies mission needs by beginning with the end in mind.

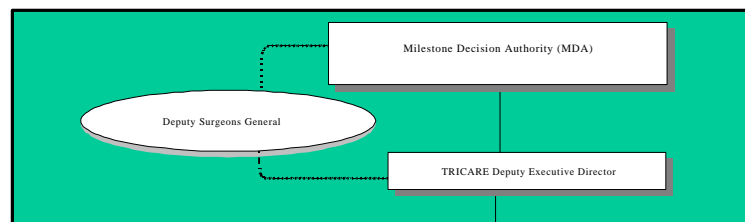
1.3 Program Management Office Scope

A variety of programs and projects are well suited for the principles of program management. As a rule, TRICARE projects that typically fall under Program Management include new initiatives for healthcare delivery; legislatively mandated demonstrations; the award of TRICARE managed care support and other contracts; existing projects earmarked for re-engineering to better meet the needs of the Military Health System (MHS); and other new TRICARE projects as designated. Sponsorship for a project to be assigned to the PMO may come from TMA, Health Affairs, the Services, or a Congressional mandate. For general guidelines for determining if a project is appropriate for the Program Management Office, **refer to Section 2.1.**

1.4 Program Management Office Structure

The following chart (**Figure 1**) shows the functional Program Management Office (PMO) structure under the direction of the TRICARE Deputy Executive Director (DED). Under the TRICARE Charter, the DED is the Program Manager for TRICARE. All sub-activities are considered projects implemented under the direction of appointed Project Managers. 'Program Manager' and 'Project Manager' designations became effective with the TRICARE Charter; therefore samples included in this guide may reference previously acceptable titles.

Figure 1
TRICARE Program Management Functional Organizational Chart



1.5 TRICARE Program Management Office Roles and Responsibilities

The TRICARE PMO integrates the systems, activities, participants and processes which are necessary to meet TRICARE mission requirements as identified by the TRICARE Milestone Decision Authority (MDA) and Deputy Executive Director (DED). The TRICARE PMO executes a program management model that combines the established TMA lines of executive authority with cross-functional participants from the Military Health System (MHS) and industry to provide a tailored program management organization utilizing DoD 5000.2-R guidance. The TRICARE PMO clearly identifies stakeholders and their corresponding responsibilities and centralizes TRICARE program management decision making to consolidate, integrate and prioritize requirements. The TRICARE PMO employs a disciplined, repeatable process that empowers working-level professionals to meet mission requirements and perform strategic analyses for timely executive-level decision making.

Milestone Decision Authority (MDA)

The **TRICARE Milestone Decision Authority (MDA)** is the final authority for all TRICARE related activities. The MDA approves the advancement of a project from one phase to another. The MDA provides direction, oversight and final approval for all projects.

Deputy Surgeons General (DSGs)

The **Deputy Surgeons General (DSGs)** serve as a first level advisory committee and review projects and timelines as presented by Project Managers. The DSGs also provide input from the Service perspective through the nomination of Service representatives and participants.

TRICARE Deputy Executive Director (DED)

The **TRICARE Deputy Executive Director (DED)** is primarily responsible for oversight and management of the planning, integration, and coordination of one or multiple projects that fall under TRICARE Program Management. Depending upon scope and complexity, projects may be assigned to full-time Project Managers by the TRICARE DED. The TRICARE DED is accountable to

Deputy Director for Resource Management chairs the committee. In coordination with the Health Services Delivery Steering Group, the RMSC makes project funding recommendations. The group also reviews cost estimates submitted with change packages.

Health Services Delivery Steering Group (HSDSG) The **Health Services Delivery Steering Group (HSDSG)** is comprised of senior representatives from each of the Services and TMA Chief of Staff. The group reviews updates from TRICARE Integrated Project Teams and ensures the respective DSGs are properly informed of TRICARE projects.

TRICARE Management Activity (TMA) Directors The **TRICARE Management Activity (TMA) Directors** are responsible for the oversight and management of the TMA directorates. The directors are accountable for the performance of the Project Managers from their directorates and are responsible for knowing Integrated Project Team progress through reports from their respective Project Managers and Integrated Project Team members. All TMA Directors will be assigned as a counselor to certain projects to monitor progress, track milestone achievement and provide guidance to the Project Managers.

Program Management Office (PMO) The **Program Management Office (PMO)** provides an approved program management model for TRICARE and adds structure and processes, where appropriate, to meet the execution and integration requirements of projects assigned under the TRICARE PMO discipline. This office provides consultants to facilitate issue resolution, monitor project development and track timelines/milestones. Reports and updates are provided on a routine basis to the DED to obtain concurrence. When appropriate, the PMO staff facilitates the integration of projects to ensure all aspects of TRICARE projects are supportive and complementary.

Project Manager (PM) The **Project Manager (PM)** is appointed in writing by the DED. The PM is responsible for the planning, integration, management and

Project Coordinator (PC)	The <i>Project Coordinator (PC)</i> is assigned to a particular project by the PMO office. The PC is responsible for providing quality program management support by assisting the PM with the activities, issues, decision making, communications, reporting and overall management of the Integrated Project Team. The PC provides analytical, technical, and logistical support by documenting and tracking project activities, deliverables and briefing schedules. The PC consults with the PM on a regular basis to assist with the project's day-to-day activities. PC support functions cease when Integrated Project Team work is completed.
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Integrated Project Team (IPT)	The <i>Integrated Project Team (IPT)</i> facilitates teamwork and collaborative decision making to generate recommendations related to the assigned project objectives. Each member represents a functional area or contributes subject matter expertise to meet the project deliverable. Composition will be determined by the scope and complexity of the project, along with staffing needed to support the PM in the management of the project. Membership on the IPT consists of senior staff officers within the TMA Directorates, Services, and Lead Agent Offices and other organizations as identified by the PM.
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Working Integrated Project Team (WIPT)	The <i>Working Integrated Project Team (WIPT)</i> is responsible for specific issue resolution as assigned by the PM. Potential issues are forwarded to the PM for dissemination to the WIPT chair. WIPTs are appointed and empowered by their work area and participate in resolving specific issues related to the PMO project. WIPTs may work a specific issue for the IPT and present a recommended solution and/or alternatives for IPT consideration and action.
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Formal Working Integrated Project Team (WIPT)	The <i>Formal Working Integrated Project Team (WIPT)</i> is similar to an IPT in that the formal WIPT scope, length, and mission is approved by the TMA Directors and Deputy Executive Director, and a WIPT Project Officer (PO) is formally appointed. The PO requests membership nominations from Services, TMA, and/or external organizations (as necessary).
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IPT due to its scope. The WIPT PO coordinates and informs the IPT PM the forward progress of clearly defined WIPT deliverables/objectives.

The **TRICARE Management Activity (TMA), Services and Lead Agent (LAS)** are responsible for providing qualified, empowered staff to participate in the TRICARE PMO project as IPT WIPT members. As team members, this staff may be asked to determine joint requirements, provide schedules and project deliverables, facilitate various sub-projects, and evaluate or provide comments on projects at various stages of delivery. These representatives are expected to serve as liaisons to their appointing organizations and to coordinate feedback with the Director and PMs at regularly scheduled intervals.

SECTION 2

Program Management Office Process

- ❖ *Identification of a Program Management Office Project*
- ❖ *Selection/Appointment of a Project Manager*
- ❖ *Project Manager Roles and Responsibilities*
- ❖ *Project Coordinator Responsibilities*
- ❖ *Identification of an Integrated Project Team*
- ❖ *Identification of Working Integrated Project Teams*
- ❖ *Project Closeout*

2.1 Identification of a Program Management Office Project

The Milestone Decision Authority (MDA) or Deputy Executive Director (DED) will identify which projects will fall under PMO oversight and supervision (**See Section 1.3**). The DED will select and/or appoint a PM based on experience, knowledge, and complexity of the project. The PM will determine the scope of the project for the Director, PMO office to assist with planning activities for the project and assignment of support staff.

2.1.1 Program Management Office Project Criteria

General guidelines for determining if a project is appropriate for Program Management include meeting the following criteria.

- The project has a definable beginning and end point, follows a life cycle from start to completion, and is defined as a project requiring input from many sources versus an individual task or process improvement activity.
- The project is more than moderately complex resulting in medium risk to the success of the TRICARE mission.
- The project is identified by either the MDA or the TRICARE DED as requiring program management oversight.

2.1.2 Accelerated Projects

Some initiatives requiring program management oversight do not fit the classic PMO definition of a project. To ensure we recognize these requirements as they arise and to facilitate our accomplishment of the mission, the guidance for accelerated projects is provided. The structure described below is somewhat more flexible than the more deliberate Program Management framework, and allows the Project Manager and associated action officers more latitude in developing schedules, meeting short-term requirements and reporting on milestones over a more condensed time period.

To meet the criteria for designation as an accelerated project, either the MDA or

- Definable end product and/or deliverable;
- Project Initiative is more than moderately complex resulting in at least medium risk to the success of the TRICARE mission.

2.2 Selection/Appointment of a Project Manager

Once a project has been identified for the PMO process, the DED will appoint a Project Manager (PM) to head up the new project. The DED will send an appointment letter **(Sample A)** notifying the member of his/her assignment. This appointment may be coordinated and discussed with other TMA Directors before a formal appointment letter is sent. Depending on the scope of the project, a Co-Project Manager or Deputy Project Manager may be assigned to provide additional management support. The PMO will assign both a primary and secondary Project Coordinator to work with the PM and provide program management support.

SAMPLE A - PROJECT MANAGER APPOINTMENT LETTER

MEMORANDUM FOR DEPUTY DIRECTOR, TRANSFORMATION INTEGRATION
(ATTENTION: DEE DODSON MORRIS, JD)

SUBJECT: Project Manager Appointment for NBC Medical Readiness

You are hereby appointed the Project Manager for NBC Medical Readiness. The Department of Defense Regulation 5000.2-R and the TRICARE Program Management Office (PMO) User's Guide will guide you in your duties and responsibilities. Copies of these documents are available at www.tricare.osd.mil/pmo. The NBC Medical Readiness IPT will address recommendations #2 and #5 in the Government Accounting Office Report: Chemical and Biological Defense, DoD Needs to Clarify Expectations for Medical Readiness (GA0-02-38).

As the TRICARE Project Manager for NBC Medical Readiness you are responsible and accountable for coordinating the day to day activities of the project and for ensuring that the project progresses satisfactorily through the tailored TRICARE PMO model. The Project Manager periodically reports status and progress to the TRICARE Deputy Executive Director (DED).

As the NBC Medical Readiness Project Manager you are specifically responsible for:

- serving as the Chair of the NBC Medical Readiness Integrated Project Team (IPT);
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE DED;
- briefing the IPT recommended project schedule to the TRICARE DED for approval;
- providing assessments of project status and risk reporting variances to the TRICARE DED;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- ensuring that the appropriate stakeholders are actively engaged in the project;
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment is expected to last 12 months. The assignment will terminate after all requirements of the IPT are met or at the request of the TRICARE DED.

2.3 TRICARE Management Activity Project Manager

Roles and responsibilities applicable to Project Managers (PMs) across all projects are bulleted in the sample appointment letter (**Sample A**). Though project accountability remains with the PM, the expectation is for the PM to use all available resources, such as, IPT stakeholders, Project Coordinators (PCs) and other TMA assets, to assist in mission accomplishment. Below is a more detailed listing of a successful PM's profile, roles and responsibilities.

2.3.1 TRICARE Management Activity Project Manager Profile

TMA PMs are senior leaders who have demonstrated strong organizational skills and have a record of proven top performance. They have the confidence and support of their nominating Director and should quickly acquire or hone appropriate program management skills. To assist PMs in the endeavor, requisite training will be provided as necessary. Key ingredients of the successful PM include the following:

- General knowledge of DoD 5000 series methodology.
- Understanding of the Program Management process as applied to TMA
 - Work Breakdown Structure (WBS)
 - Task lists
 - Risk management
 - Phased planning/milestone driven method
- Understanding of TMA hierarchy, chain of command and approving bodies.
- Commitment to the project mission.
- Team coordination and consensus building.
- Proactive attitude toward project issue resolution.
- Time management skills.
- Communication and analytical skills.
- Results driven mind-set and an ability to multi-task.
- Long term and big picture perspective.
- Ability to delegate appropriately.
- Effective meeting management skills.
- Effective use of VTC, teleconferencing, web-based and in-person

- Spearhead and coordinate IPT activities to generate project requirements and recommendations.
- Survey information on related initiatives both within and outside TMA.
- Assess current organizational systems and identify areas needing expansion or reform.
- Evaluate strategic, financial, political and technological risks associated with project requirements and timeline.
- Ensure appropriate and consistent communications occur among IPT.
- Delegate tasks to IPT members and project support personnel to optimize IPT activities.
- Establish and monitor the progress of WIPTs.
- Generate core documents reflecting project objectives & requirements, timeline, budget constraints, technological interfaces and implementation plan.
- Review direct care system and managed care support contract implications.
- Draft policy, memorandums, legislative language and managed care support contract modifications required to implement project recommendations.
- Apply TMA marketing capabilities, i.e. Communications & Customer Service (C&CS) Directorate as needed.

Briefings

- Update chain of command on project status at scheduled or appropriate intervals.
- Create concise, relevant and timely briefs for executive decision bodies (e.g. TMA Directors, Deputy Executive Director, Deputy Surgeons General) outlining IPT progress, budget requirements, critical decision points and project stoppages.
- Staff project proposals through TMA Directorates and Services for comment prior to finalization of recommendations.
- Be prepared to brief relevant outside agencies as directed, e.g., Office of the Secretary of Defense (OSD), Medical Personnel (MEDPERS).

Funding & Resources (as appropriate)

- Assess direct care impacts at Military Treatment Facility (MTF) and

- Enlist the services of contractors to obtain third party cost estimates and assessments.
- Review technology based initiatives with Information Management, Technology & Re-engineering (IMT&R) Directorate and address IMT&R Functional Integrated Workgroup (FIWG), if appropriate.
- Submit cost estimates for Program Objective Memorandum (POM), i.e., the out-years.
- Identify funding stream and coordinate through TMA Resource Management Directorate.
- Consider costs related to the continuance of the project after the close of the IPT.
- Align project funding approval and subsequent implementation target dates with Planning, Programming and Budget System (PPBS).
- Submit fact sheets for Contracted Advisory Assistance Services (CAAS) and non-CAAS budget requirements, i.e., near-term requirements.
- Identify PMO funded activities and non-PMO funded activities.
- Review cost estimates from third party contractors, government team and MCSC to determine project cost estimate for Change Management Board (CMB) approval.
- Monitor project costs during contractor negotiations with assistance from Contracting Officer (CO). Obtain CMB approval for increases greater than 10%.

Project Implementation

- Coordinate with Resource Management (RM) Directorate to verify Form 789 authorizing Acquisition Management & Support (AM&S) Directorate and Operations Directorate (OD) to start work, is completed and forwarded.
- Identify and work closely with assigned Change Cycle Manager and CO to definitize project requirements, effectively communicate requirements to contractor, maintain within appropriate cost parameters and remain on schedule.
- Notify CO when communications with MCSCs is warranted.
- Continue to update costs and monitor project requirements for changes approved for out year funding.
- Develop negotiating/pricing IPT to work with MCSC to negotiate contract change

- Develop recommendations for long-term maintenance of project initiatives including, cost estimates, assignment of organizational responsibility, operational procedures and performance metrics.
- Formally closeout project by briefing DED and obtaining approval signature.
- Confirm termination date of support activities with Director, PMO.
- With assistance of PC, create closeout summary binders for PM and Director, PMO.
- Generate letters of appreciation and completion certificates for project participants, as appropriate.

2.3.3 Project Manager's Checklist

The PMO User's Guide outlines the steps to successful project completion. The Project Manager's Checklist is a tool to assist the PM in tracking tasks and reporting requirements within a phase.

PROGRAM MANAGEMENT OFFICE (PMO) GUIDE PROJECT MANAGER'S CHECKLIST

PRE-PHASE – DETERMINATION OF MISSION NEED	SECTION
<input type="checkbox"/> Project Manager Appointment	2.2
<input type="checkbox"/> Project Manager Appointment Letter	
Ø PMO Kick-off Meeting with PMO Director And Project Coordinator	4.2
<input type="checkbox"/> Project Coordinator Roles & Responsibilities	2.4
<input type="checkbox"/> Funding	6 & 5.4
<input type="checkbox"/> Review of PMO process and required documents; PMO Guide	2
<input type="checkbox"/> IPT Charter	3.4
<input type="checkbox"/> IPT Nominations	2.5
<input type="checkbox"/> IPT Membership Appointment Letter	2.5.1
<input type="checkbox"/> Mission Needs Statement	3.2
<input type="checkbox"/> Project purpose and scope	
<input type="checkbox"/> Project priorities and goals	
Ø IPT Review Briefing	4.4
<input type="checkbox"/> Milestone 0 Briefing - Mission Validation & Approval	4.5
PHASE 0 - CONCEPT EXPLORATION	SECTION
<input type="checkbox"/> IPT Meetings	2.5.2
<input type="checkbox"/> Task Assignment	
<input type="checkbox"/> Submission dates	
<input type="checkbox"/> Meeting schedule	
<input type="checkbox"/> Business Plan	3.5
<input type="checkbox"/> Milestone Chart	3.3
<input type="checkbox"/> Preliminary Primavera v3 (P3) Chart	3.7.1
Ø IPT Review Briefing	4.4
<input type="checkbox"/> Milestone 1 Briefing – Approval of Concept	4.5
PHASE I - PROJECT DEFINITION AND RISK REDUCTION	SECTION
<input type="checkbox"/> Functional Requirements	5.2.1.2

**PROGRAM MANAGEMENT OFFICE (PMO) GUIDE
PROJECT MANAGER'S CHECKLIST**

PHASE II - MATURE & FINALIZE DESIGN/PROCESS	SECTION
<input type="checkbox"/> IPT Review Briefing	4.4
<input type="checkbox"/> Milestone III Briefing - Approval of Implementation Plan	4.5 or 5.3.1.3
PHASE III - TRANSITION IN IMPLEMENTATION/OPERATIONS SUPPORT	SECTION
<input type="checkbox"/> Evaluation Activities	2.3.3
<input type="checkbox"/> Maintenance Activities	2.3.4
<input type="checkbox"/> Milestone IV Briefing - Approval of Transition Plan (optional)	4.5
POST-PHASE – TRANSITION OUT	SECTION
<input type="checkbox"/> Closeout Project	2.7
<input type="checkbox"/> Brief DED	2.7.1
<input type="checkbox"/> IPT Final Binder	2.7.2
<input type="checkbox"/> Appreciation Letters	2.7.3
<input type="checkbox"/> Project Manager	
<input type="checkbox"/> IPT Members	
<input type="checkbox"/> Project Coordinator	

2.4 Project Coordinator Responsibilities

The primary role of the Project Coordinator (PC), is to assist the Project Manager (PM) by providing program management support. The PC communicates with the PM on a regular basis to help with the daily activities of the project. The PC's responsibilities include, but are not limited to:

- Preparing core documents for PM approval including the Mission Needs Statement, Charter, Business Plan, Milestone Chart, and Project Management Plan;
- Monitoring and updating project schedules;
- Identifying stakeholders;
- Scheduling and facilitating IPT meetings to include drafting IPT meeting agenda and maintaining minutes of the meetings acknowledging attendees and clearly indicating any decisions agreed upon and any dissenting votes;
- Ensuring a "working issues matrix" of all issues is recorded, including entry dates, resolution dates and a description of actions taken;
- Assisting the PM by ensuring status reports and issues requiring senior level input are forwarded to the next appropriate level in the IPT structure, i.e. PM and Director, PMO;
- Drafting IPT Review Briefings, Milestone Approval Briefing, and other briefings as needed for PM;
- Potentially supporting and coordinating WIPT activities with IPT members;
- Researching and analyzing proposed policy recommendations;
- Assisting with the development of marketing materials;
- Acting as informational liaison between IPT members, TMA, PMO staff, and the PM;
- Drafting, coordinating and maintaining accurate project information for the website;
- Developing a good working relationship with the PM;
- Promoting integration of separate projects as applicable;
- Drafting project closeout documentation. **(See Project Closeout Section 2.7)**

2.5 Identification of an Integrated Project Team

2.5.1 Nomination/Appointment of Integrated Project Team
Members

Each IPT should be composed of appropriate, diversified team members working together for the success of the project and enabling the PM and other decision makers to form correct, informed decisions at the proper time, while directing the project to completion. It is recommended that IPT membership is kept to a manageable size of approximately 8-10 members, however size may vary depending upon the specifics of the project. Cooperation within the IPT is essential; open frank discussions with full disclosure are imperative.

The PM, with the assistance of the PC, is responsible for distributing IPT nomination letters **(See Sample B)** to the Lead Agents, Services, and TMA Directorates or other organizations. Nominations are based on requisite knowledge, expertise and overall ability to address the development and implementation of the functional and operational requirements of the project. The nominee must be authorized and empowered to act on behalf of his/her organization. For continuity purposes, the person appointed must be available to serve throughout the development of the project.

SAMPLE B - IPT NOMINATION LETTER

MEMORANDUM FOR DIRECTOR, ACQUISITION MANAGEMENT & SUPPORT
DIRECTOR, COMMUNICATIONS & CUSTOMER SERVICE
DIRECTOR, HEALTH PROGRAM ANALYSIS & EVALUATION
DIRECTOR, INFORMATION MANAGEMENT, TECHNOLOGY
& REENGINEERING
DIRECTOR, OPERATIONS
DIRECTOR, RESOURCE MANAGEMENT

SUBJECT: Appointment of Representative for Enterprise Wide Scheduling and Workload
Forecasting Integrated Project Team

Your support is requested in the development and implementation of deliverables for the Enterprise Wide Scheduling and Workload Forecasting Integrated Project Team (EWSWF IPT). This team will recommend the future business model, requirements, and software solutions for Military Health Service scheduling, registration, and workload forecasting needs.

As the TRICARE Deputy Executive Director (DED), I have directed the formation of an IPT to be comprised of representatives from the Services and functional areas within the TRICARE Management Activity (TMA). The IPT shall work collaboratively to address all issues regarding Enterprise Wide Scheduling and Workload Forecasting.

I request that you appoint an individual from your Directorate to serve on this IPT. The individual should have the requisite authority and expertise to speak for your functional or operational area considering the project's scope. If you feel that a full time IPT representative from your Directorate is not necessary, please provide a point of contact to attend IPT meetings on an as needed basis. The IPT begins February 2002 and expires when its recommendations are delivered. The IPT will last approximately 10 months. The person appointed should preferably be able to serve throughout the duration of the IPT.

In your appointment memorandum, please use language that clearly describes the authority and limitations of authority that the appointed IPT member possesses. Please submit a copy of your appointment memorandum to me within two (2) weeks of the date of this memorandum. If you have any questions, please contact Col Alan Smith, Project Manager, Enterprise Wide Scheduling and Workload Forecasting IPT at 703-998-0800 ext. 20, or by email at alan.smith@tma.osd.mil

2.5.2 Integrated Project Team Members' Roles and Responsibilities

- Assist the PM in developing strategies and project planning, as requested;
- Assist in establishing plans of action and appropriate milestones for particular issues requiring expertise;
- Propose tailored documents and milestone requirements;
- Review and provide timely input on documents and read-ahead materials;
- Assist in the resolution of project related issues in a timely manner;
- Assume the responsibility of informing key personnel within their organization of the project's issues, as well as applicable documents or portions of documents as they pertain to the project;
- Ensure alternate IPT members are briefed by the primary member and kept knowledgeable of the current status of the project.

2.5.3 Integrated Project Team Code of Conduct

In general, decisions made within the IPT are binding for its members. Although all members may not agree with each IPT decision, it is imperative that all IPT members ultimately defer to team consensus. Failure to comply may result in termination of IPT membership by the PM. The PM reserves the right, as the designated chair, to dismiss uncooperative members. Grounds for IPT dismissal include, but are not limited to:

- Failure to execute a Confidentiality Statement (CS), if needed (**See Section 2.5.4**);
- Excessive absenteeism at scheduled IPT meetings;
- Negatively contributing to overall IPT cohesion;
- Failure to perform assigned tasks in an efficient, timely manner.

Specifics in line with these guidelines will be established by individual PMs, with approval of the Director, PMO or MDA, to fit the individual nature and disposition of their particular IPT. This code of IPT conduct will be disseminated to all IPT members at the inception of the IPT. Those identified as alternates by IPT

inadvertent release of a confidential government cost estimate, or premature release of Request for Proposal (RFP) content that would provide an unauthorized recipient with an unfair advantage in drafting a proposal. Such release outside of government control to vendors can legally jeopardize and/or derail multi-million dollar procurements, and cost the government additional millions in legal mitigation costs in the event of a formal protest.

The PM, through his/her operational interactions with TMA Contract Management Division, DSS-W, or the Office of General Counsel, shall be made aware of what information may fall into this category. Common sense and awareness of procurement rules generally dictates heightened sensitivity to the security and release of "government only" information of an official nature to only those with an "official need to know".

The following are suggestions to ensure confidentiality is not breached by the IPT.

- Physically safeguard sensitive information by storing it only in secure locations. Never take sensitive documents home.
- Conspicuously label documents as 'Procurement Sensitive' in the header and footer.
- Obtain signed Confidentiality Statements prior to the release of information (**See Business Plan in Appendix B for more detail.**)
- Make cautionary verbal statements to participants prior to the release of information. For example: "The information contained in this document (be specific) [or disclosed in this conversation] is considered by the Contracting Officer to be Procurement Sensitive. Release of this information outside of the government, or to those without an official need to know, is prohibited."
- Collect and destroy paper copies of the information at the conclusion of each meeting. Account for every page of every document.
- Ensure there is competent release authority and approval prior to any disclosure. In most cases, that authority will be the Project Manager or Contracting Officer
- Maintain a written record of what was released and when it was released. The signed confidentiality statement referenced above should accompany the written record or copy of what was released.
- At meetings attended by contractors, avoid conversations related to

2.5.5 External Participants

The PM approves all external participants of IPT meetings. Invitations may be extended in an effort to solicit further input on specific issues, seek clarification in significant areas as identified by the IPT, or when the primary or alternate is unavailable. As a rule, external participation is limited to an informational role at IPT meetings. Invited IPT participants shall not be privy to procurement sensitive information or be part of the decision-making process. Moreover, it is the responsibility of the PM to secure the integrity of any procurement sensitive or otherwise privileged information.

An IPT member may request that a designated representative attend the meetings when the primary or alternate representative is unavailable. If the designated representative attends, the PM or WIPT chair must be notified. All meeting attendees who are not members of the IPT or WIPT must receive an invitation or prior approval from the PM.

Several policies and procedures apply when Managed Care Support Contractor (MCSC) participation is required at an IPT meeting. Prior to initiating a request for Government directed contractor travel, contact the Chief, Contract Administration Office, TMA/Aurora for guidance and assistance with contractor notification.

2.6 Working Integrated Project Teams

2.6.1 Identification of Working Integrated Project Teams

The Working Integrated Project Team (WIPT) is a short-term entity that works on a specific issue or problem to provide solutions or options to be decided upon by the IPT. This allows decision making at the lowest possible level.

While the IPT reviews progress with the project on a broad and strategic level, there will be instances when functional expertise for an identified issue will require more analysis by personnel who can devote the time necessary to develop a solution, or personnel who are functional experts in a field. WIPTs are working teams that are formed by the PM at the recommendation of the IPT to work on the resolution of a particular issue. The role of a WIPT is to provide specialized data and/or support in a defined area of expertise that may lie outside

- Integrate with an existing group;
- Establish a group of subject matter experts; or
- Establish a cross-functional WIPT.

The PM has the flexibility to work the composition of the WIPT with IPT members. The WIPT Chair should be an IPT member selected by the IPT working group or the PM. Approval of members selected for participation must be obtained from the Directors of the organization to which they belong. Approval may be obtained either formally through an appointment letter, or informally through an e-mail request.

It is important to clearly define the expectations, responsibilities, boundaries and authority prescribed to each WIPT member. Following receipt of organizational approval, assignments of WIPT issues may be delegated as required. Upon satisfactory completion and submission of the assigned task, the WIPT Chair then formally requests to dismiss. After concurrence from the PM and IPT the WIPT may be closed.

2.6.2 Identification of Formal Working Integrated Project Teams

The Formal Working Integrated Project Team (WIPT) is similar to an IPT in that the formal WIPT scope, length, and mission is approved by the TMA Directors and Deputy Executive Director, and a WIPT PO is formally appointed. The PO requests membership nominations from Services, TMA, and/or external organizations (as necessary), facilitates teamwork and collaborative decision making regarding WIPT objectives, prepares core program management documentation, and provides leadership briefs at milestone decisions. A formal WIPT and an IPT differ in that a formal WIPT is a subordinate group to a pre-existing or Overarching IPT (OIPT) under leadership of the IPT PM due to integration of multiple, related missions or the dependency of objectives and deliverables. In the absence of the need for an Overarching IPT, this group would be defined as an IPT due to its scope. The WIPT PO coordinates and informs the IPT PM the forward progress of clearly defined WIPT deliverables/objectives.

2.7 Project Closeout

- Accomplishments/successes
- Unresolved concerns
- Recommendations

2.7.2 Internal Audit of Documents

The PC will create a Final Closeout Binder for the Project Manager and the Director, PMO Office. Binders will include all of the necessary documentation from the project.

2.7.3 Closeout Letters (See Sample D)

- Closeout letters will be sent to Project Manager(s) & Project Coordinator(s) from the DED, thanking them for their participation in the IPT and informing them that the IPT is now formally closed.
- It is the responsibility of the PM to send closeout letters to the individual IPT members.

2.7.4 Completion Certificates

Completion Certificates will be sent to Project Manager(s) and Project Coordinator(s).

Please be aware that although the project is officially closed there may be activities that must continue to be monitored by the PM or staff.

SAMPLE C - CLOSE OUT DECISION PAPER

**Data Assurance & Privacy
Integrated Project Team Closeout
Decision Paper**

Submitted to: Maj Gen L. Randolph

<Date>

Project Identification

Project Manager: Dr. Richard Guerin
703-681-3636, ext 5001

EXECUTIVE REPORT

Mission of the Project:

A multitude of laws, directives and regulations govern the management, handling and transfer of sensitive information, e.g., the Privacy Act, the Computer Security Act, the Health Insurance Portability and Accountability Act (HIPAA), and the Freedom of Information Act. The Data Assurance & Privacy (DAP) Integrated Project Team (IPT) was convened to address issues and challenges facing TRICARE related to the collection, release, use, storage, protection and distribution of patient sensitive data and additionally assess any associated legal liabilities.

Key Findings:

- Current Military Health System (MHS)/TRICARE guidance and policy are either not available, inconsistent or lack uniformity, leaving the MHS vulnerable to legal liability;
- Automated systems are being proliferated across the MHS without regard to or an understanding of applicable laws, directives and regulations;
- Users of patient sensitive data/information and automated systems containing this type of data are not aware of and/or not in compliance with applicable laws, directives and regulations.

Actions Taken/Accomplishments:

- IPT members conducted informal surveys to assess data privacy concerns;
- Developed practical, easy to understand guidance (**Attachment 1**) for distribution by the Deputy Surgeons General (DSGs) to military treatment facility (MTF) commanders. (Guidance supplements Assistant Secretary of Defense (Health Affairs) interim privacy regulations policy memorandum.);
- Created training website prototype for 'every day user'. See **Attachment 2** for site text.

Unresolved Concerns:

- Use of personal digital assistants/wireless devices. (**Attachment 3** describes some of the critical factors surrounding this issue.)

Recommendations:

1. Forward supplemental guidance package to the DSGs under Mr. Carrato's signature requesting that the package in turn be provided to MTF commanders for distribution to the appropriate personnel.
2. Refer the following issues/responsibilities to the TRICARE Management Activity (TMA) Privacy Office, Information Management, Technology & Reengineering Directorate and/or Optimization and Integration Directorate's Education Division.
 - Development of an MHS policy on the use of personal digital assistants and other wireless devices.
 - Updates to and subsequent dissemination of the supplemental guidance package.
 - Administration and deployment of the training website.
 - Obtain final coordination of website content with Optimization and Integration Directorate's Education Division and Office of the Secretary Defense (OSD) Privacy Office.
3. Forward CD-ROM version of website to DSGs advising
 - Integration of website into current training, where feasible;
 - Development of a methodology to track personnel's successful completion of the test;
 - Annual certification of all pertinent personnel;
 - Designation of a Service POC.

Concur:

Permission to closeout this project.

Leonard M. Randolph, Jr., Maj Gen, USAF, MC

SAMPLE D - IPT CLOSEOUT LETTER

MEMORANDUM FOR OPERATIONS DIRECTORATE

SUBJECT: Letter of Completion for Primary Care Manager by Name (PCMBN)

The assignment of an individual PCMBN to each beneficiary became a requirement for the Military Health System (MHS) with the issuance of the Assistant Secretary of Defense (Health Affairs) (ASD (HA)) policy letter titled: *Individual Assignment to Primary Care Manager by Name*. Prior to this policy's issuance, TRICARE Prime beneficiaries were assigned to Primary Care Manager (PCM) Teams. Subsequent to this issuance, each TRICARE Prime beneficiary was to be assigned their own individual PCM. An Integrated Project Team (IPT) was formed under the guidance of the Military Health System Operations (MHSO) Directorate to implement PCMBN systemwide.

In achieving this goal, the PCMBN IPT created a uniform implementation plan, which included TriService guidelines for PCMBN and requirements for Information Management/Information Technology (IM/IT) to support this initiative. The PCMBN IPT worked collaboratively to integrate PCMBN project requirements with those of the National Enrollment Database (NED) and Standardized Enrollment. In addition, the IPT developed process improvement, program management, marketing, and PCM assignment toolkits to support the implementation of PCMBN and the cultural shift to a Primary Care Management model for the entire Military Health System (MHS). Lastly, metrics to assess and monitor the PCMBN program were established and an idealized future state business model for PCMBN under the new Defense Eligibility Enrollment System (DEERS) was created.

The implementation phase started in January 2000. The energy that LTC Scott Goodrich has given as the Project Manager was vital to reaching this milestone. Although the implementation phase continues, the PCMBN project has successfully completed all milestones required to graduate from the Program Management Organization (PMO). I hope that the PMO guidelines and processes provided useful tools and structure for your project. I would appreciate any feedback you and/or LTC Goodrich have to offer concerning the PMO process.

I sincerely appreciate the time and expertise LTC Goodrich gave to help improve the provision of health care. There is still work to be done in the implementation phase, and I look forward to having him continue this effort.

Leonard M. Randolph, Jr.

SECTION 3

Core Documents

- ❖ *Introduction*
- ❖ *Mission Needs Statement*
- ❖ *Milestone Chart*
- ❖ *Charter*
- ❖ *Program Management Office Business Plan*
- ❖ *Project Management Plan*
- ❖ *Other Supporting Documents*

3.1 Introduction

Core documents form the foundation and track the life cycle of the project. Their purpose is to clearly delineate project missions, goals, business rules, deliverables, timelines, recommendations and implementation plans. Upon closeout of a project, core documents become the reference tools for past project activity.

3.2 Mission Needs Statement

The Mission Needs Statement (MNS) is a formatted, non-solution specific statement containing operational capability needs. It is written in broad operational terms and describes required capabilities and constraints to be studied during the Concept Exploration and Definition Phase of the project. The premise of this document is that a successful plan starts with the end vision in mind; the mission or goal must be clearly identified and stated. **See Sample E.**

More concisely, the MNS addresses a 'mission need', i.e. a deficiency in current capabilities or an opportunity to provide new capabilities, reengineer existing capabilities, or to recalibrate an approach. It is developed through broad program management structures and processes. This document should be completed within ten (10) days of the IPT PMO Kick-off briefing.

3.3 Milestone Chart

The project milestone chart (**Sample F**) is a graphic view of the program's phases and those activities that need to occur within each phase. Each phase is completed with a decision point or milestone, at which time the IPT can move on to the next phase if successful. The milestone chart is a very important step in helping the PM determine the project schedule. Milestone charts will be included in briefs to the TMA leadership and submitted to the DED each month. As of final publication of this User's Guide, all new projects will be using the new DoD 5000 format. Those projects that are already established have been "grandfathered", and will reflect the old format.

3.4 Project Charter

3.5 Program Management Office Business Plan

The Program Management Office (PMO) Business Plan (**Sample H**) enables the PM to identify the processes by which the project will be managed on a day-to-day basis. It lays out the roles and responsibilities of each of the organizations and individuals involved in the IPT process, from the MDA down to the PC. The PMO Business Plan presents the processes by which projects identified for program management and oversight shall be managed. It is provided as general guidance to assist the PM and IPT in managing the day-to-day operation of the specific program's management plan. This document is central to a successful project and requires thoughtful deliberation, meaningful participation and careful documentation. This document should be drafted with the IPT Charter approximately ten (10) days after the first IPT meeting.

3.6 Project Management Plan

The Project Management Plan (PMP) provides a comprehensive project roadmap for how the project is going to be developed and run. It covers the project schedule, financial risks, and technical risks, as well as any measures or metrics that need to be established to measure the success or outcome of the project after implementation. (**See Sample I.**) It is meant to provide a starting point and provoke thought and discussion in the various areas that comprise a project. The document is the centerpiece of a project and summarizes the project. It is an iterative document, and can be updated as needed due to project change in direction or initiative. Generally, the PMP is done within sixty (60) days of the Business Plan.

Sample E - MISSION NEEDS STATEMENT

Mission Needs Statement For Military Health System Patient Safety Project

This Mission Needs Statement (MNS) describes the required operational capabilities (mission or purpose) for the Military Health System Patient Safety Project. The MNS identifies major project objectives to which the need responds. If the MNS is carefully prepared to address the project's end result, future decisions concerning milestones, high-level activities and evaluation pieces may be easier to finalize.

I. BACKGROUND

The President issued an Executive Order on December 7, 1999, asking the Quality Interagency Coordination Task Force (QuIC) to address the issues identified in the Institute of Medicine's (IOM) report, *To Err is Human*, which estimated up to 98,000 preventable deaths at a cost of \$29 billion dollars per year associated with medical errors in the United States. The federal response addressed the issues and made recommendations to improve federal health care through the prevention of medical errors and enhancements of patient safety. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) formed a Department of Defense (DoD) Patient Safety Working Group (PSWG) in January 2000 to review patient safety in the Military Health System (MHS). The DoD Instruction (DoDI), "Military Health System Patient Safety Program" was signed January 16, 2001.

On January 29, 2001 the DoD Inspector General (IG) issued a report, "Collection and Reporting of Patient Safety Data within the Military Health System," which made several recommendations. The National Defense Authorization Act (NDAA) Fiscal Year 2001 (FY01) created additional patient safety requirements. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued new patient safety standards, which took effect in July 2001.

These recommendations and requirements were addressed in the revised DoDI, which was signed in August 2001. Sections 742 and 754 of the NDAA FY 2001 and DoDI

- Prescribe procedures in each Military Treatment Facility (MTF) to avoid medical errors and improving patient safety; focus on prevention and improving medical systems and processes to overcome preventable errors (root cause analysis)
- Require MTFs to have a Patient Safety Program
- Establish an MHS Patient Safety Center (MHSPSC), to include an MHS Patient Safety Registry (MHSPSR), through the Armed Forces Institute of Pathology (AFIP)
- Establish a Patient Safety Council
- Establish two Centers of Excellence (COEs) in the MHSPSC to develop programs to improve communication, coordination, and teamwork
- Comply with requirements for confidentiality of medical quality assurance regulations (10 U.S.C. 1102)
- Establish a Healthcare Team Coordination Program

To date, the PSWG has made significant progress toward achieving these requirements. They have collaborated with the Veteran Affairs' (VA) Patient Safety Center (PSC), the QuIC Task Force, the Agency for Healthcare Research and Quality (AHRQ), the Center for Medicare and Medicaid Services (CMS), the Naval Safety Center, the National Quality Forum (NQF), the Institute for Healthcare Improvement (IHI), the Leapfrog Group, and others. A Patient Safety Handbook, training materials, and a Pilot Training Program, similar to the DVA program, was developed and implemented in DoD in October 2000. The PSWG worked with the QuIC and IHI to develop a breakthrough series on improving safety in high hazard areas (Intensive Care Unit, Operating Room, Emergency Room, and Labor & Delivery) that ran from September 2000 to May 2001. Members of the PSWG and their MTF representatives participated in the series. The PSWG developed a charter for the Patient Safety Council. The PSWG continues to support the work of the MTFs by providing training tools, and a standardized reporting system. This will allow the MTFs to establish their patient safety programs and meet the JCAHO Patient Safety standards. The PSWG has standardized the reporting tool for root cause analysis, which will allow data comparisons with the VA. Moreover, they have developed a MHSPSC and MHSPSR within AFIP and developed a Healthcare Team Coordination Program.

The PSWG developed a patient safety education rollout plan for training the MHS staff for FY 2001 and 2002. Over 450 people have been trained. The FY 2003 plan is under development and may include additional training classes either in the continental United States (CONUS) or outside the continental United States (OCONUS) to meet the training needs of the MTFs and the MHS as the system and the number of staff involved in the

AFIP MHSPSC for ten teams to be trained in this methodology. The NDAA requires expansion into one specialty per year. Work has begun on the development of an obstetrics program.

The Air Force developed the Medical Team Management program, which applies the principles of crew resource management techniques in the medical setting and concentrates on communication and situational awareness skills using scripted drills that can be integrated into skill-based training requirements. It is being rolled-out to all Air Force facilities with high hazard areas. The program will be offered in the Navy and Army and in other Air Force facilities when the initial rollout is completed.

II. STATEMENT OF NEED

According to estimates in the medical literature, as many as 98,000 deaths occur in the United States each year due to errors in medical care not related to the patient's underlying condition; as many as 50% of such deaths may be preventable. The MHS has taken the initiative to minimize harm to patients by developing a robust Patient Safety Program centered on the identification and correction of defective processes and systems. The MHSPSP promotes the establishment of "a culture of safety" within the MHS. The MHSPSP will develop and promote a comprehensive program that is appropriate to the MHS mission, scientifically based, cost efficient, and improves patient safety outcomes.

A. MAJOR PROJECT OBJECTIVES

The PSWG has made strides in the establishment of the MHSPSP. The Patient Safety Integrated Project Team (IPT) composed of a representative group of senior health policy experts from the Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity (TMA), military Services, AFIP, and the Uniformed Services University of the Health Sciences (USUHS) will work collaboratively with the PSWG and other agencies as appropriate to fully implement the MHSPSP.

The Patient Safety IPT major objectives are to:

- implement the Patient Safety Program within the MHS,
- establish, maintain, improve monitoring programs required by regulation,
- educate and train MHS Patient Safety personnel on key issues,
- maintain professional liaison with key Patient Safety organizations and leadership, and
- utilize cutting edge techniques to effect change and implement safe practices

B. KEY CONSTRAINTS

The most immediate constraint to the success of the MHSPSP is funding for this program. Financial support will be needed for the following:

- the Military Health System Patient Safety Center and staff,
- a Patient Safety Manager within each MTF,
- the establishment of an Information Management/Information Technology (IM/IT) database system,
- the establishment of a patient safety education center at USUHS,
- the Military Health System Patient Safety Program training,
- the Healthcare Team Coordination training,
- use/access to an independent external database, and
- the export of the Military Health System Patient Safety Program to the purchased care system, operational forces, and the MHS ambulatory care system.

C. DURATION

The IPT began February 2002 and is estimated to extend approximately 10 months. However, the IPT will conclude when a comprehensive plan for implementation of the MHSPSP has been approved or at the request of the TRICARE Deputy Executive Director.

III. APPROVALS

CAPT Francis Stewart, Co-Project Manager	Date
--	------

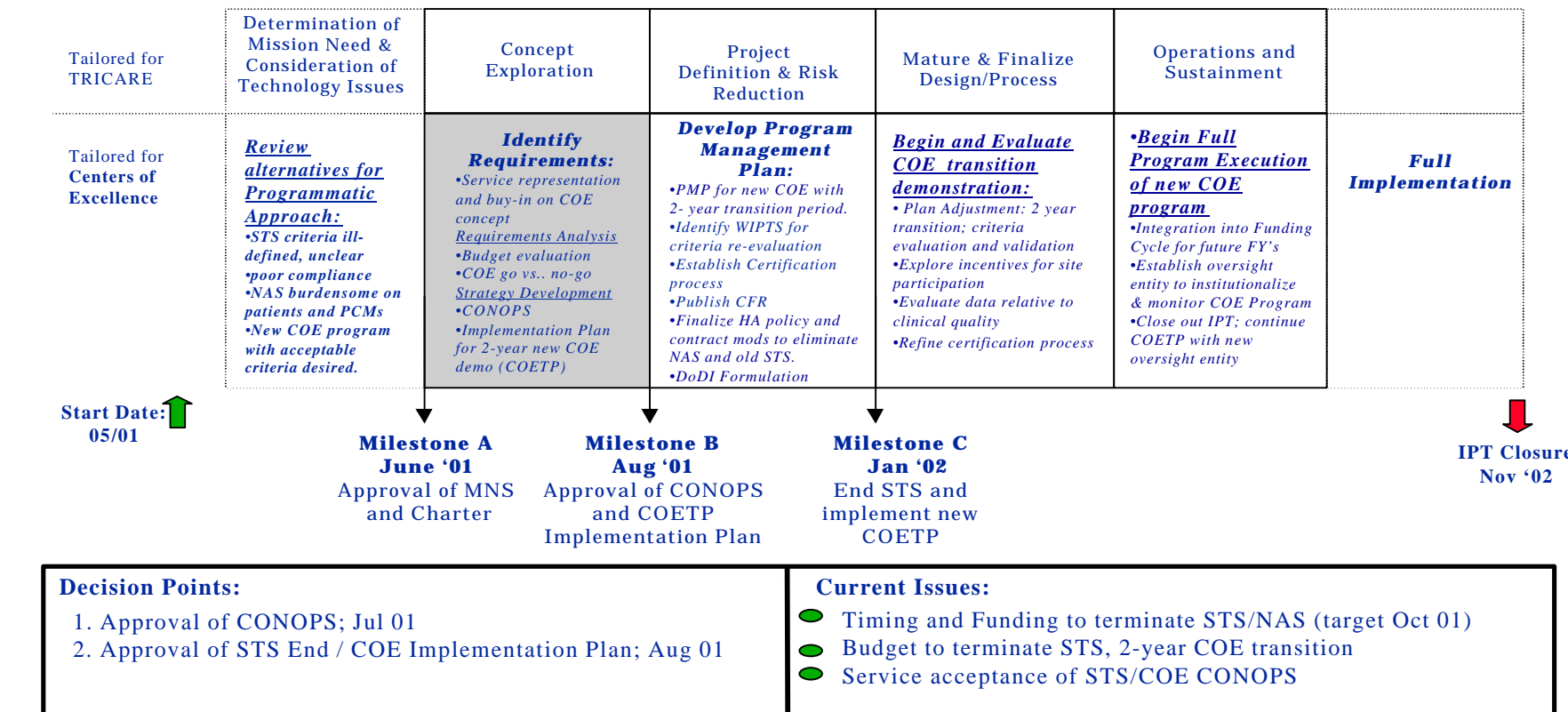
Ms. Marion Gosnell, Co-Project Manager	Date
--	------

Leonard M. Randolph, Jr., Maj Gen, USAF, MC TRICARE Deputy Executive Director	Date
--	------



SAMPLE F - MILESTONE CHART

COE Milestone Chart



Legend: [Task Completed] Task Completed [On Going] On Going [Caution] Caution [Progress Stopped] Progress Stopped [Current Phase] Current Phase

SAMPLE G – PROJECT CHARTER

CHARTER
Military Health System
Nuclear, Biological, Chemical
Medical Readiness

1. Purpose

The primary purpose of Nuclear, Biological, Chemical (NBC) Medical Readiness Integrated Project Team (IPT) is to address recommendations #2 and #5 in the Government Accounting Office’s (GAO) report: “Chemical and Biological Defense: DoD Needs to Clarify Expectations for Medical Readiness” (GAO-02-38). Recommendation #2 advocates the Services and Joint Staff support the completion of the Common User Database (CUD) while recommendation #5 recommends that the Services develop and maintain information management systems to monitor Chemical/Biological training and track the proficiency of medical personnel.
2. Scope of Activity

The team will prepare a Statement of Work and let the contract for CUD when FY 03 funds become available. Additionally, the team will develop or identify/validate, for DoD-wide implementation, the optimal informational management system to become the standard tracking system for specified training within DoD.
3. Membership

Deputy Director, Transformation Integration, Deployment Health	Dee Dodson Morris
Army Surgeon General Representative	LTC Debra Schnelle
Navy Surgeon General Representative	CDR Reggie McNeil
Air Force Surgeon General Representative	Member TBD
Coast Guard Homeland Security Representative*	LCDR Robert Styron
Army National Guard Bureau Office of Surgeon General	COL Deborah Wheeling
Office Chief, Army Reserve, Surgeons Office	COL Paul Ruble
The Air Surgeon, Air National Guard	Member TBD
TMA Directorate, Program Operations	Member TBD
TMA Directorate, IMT&R	Douglas Lake (Training)
TMA Directorate, IMT&R	Garv Corrick (CUD)

Chair, Modeling and Simulation Requirements Panel John White
(JSMG)

* Non voting member

A Contracting representative will be required for consultation in the latter stages of the IPT as recommendations are made on the CUD contract and other issues that may arise involving the information management system for recommendation #5.

4. Meetings

Meetings are held at the call/request of the Chair. IPT meetings will be initially held on a weekly basis. Once the program is underway an evaluation will be conducted to determine if the frequency of IPT meetings should continue on a weekly basis or be reduced. Periodic evaluations throughout the life cycle of the IPT will continue to assess the frequency of the meetings.

5. Deliverables

Deliverables include a Mission Needs Statement, Milestone Chart, PMO Business Plan, a program timeline etc. The Chair/Deputy Chair will publish the approved minutes. The team will also provide a Statement of Work for the CUD by May 2002 provide a POA&M to OASD (HA) by May 02, let the CUD contract as soon as FY 03 funds become available, and complete a response to Recommendation # 5 Mar 03.

6. Duration

This IPT is expected to last 12 months. The NBC Medical Readiness IPT will terminate once its findings and recommendations have been briefed to the MHS senior leadership and all DoD proposed milestones have been met.

Leonard M. Randolph, Jr.,
Major General, USAF, MC
Deputy Executive Director

SAMPLE H - PMO BUSINESS PLAN

Program Management Office
Business Plan
for
Military Health System
Patient Safety Project
Integrated Project Team

Ms. Marion Gosnell
Marion.Gosnell@tma.osd.mil
703-681-0064
Senior Advisor

CAPT Frances Stewart
Frances.Stewart@ha.osd.mil
(703) 681-1703
Program Director

**Program Management Office
Business Plan
For
Military Health System
Patient Safety Project**

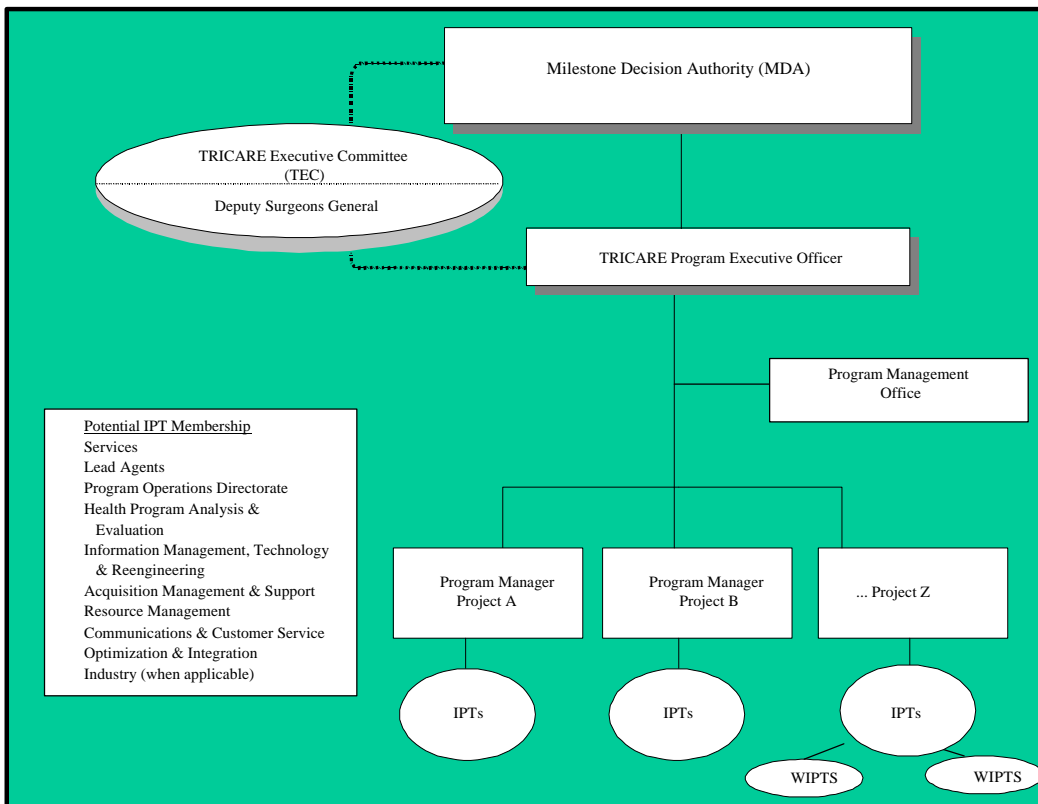
This Program Management Office (PMO) Business Plan presents the processes by which the Military Health System (MHS) Patient Safety Project shall be managed. This document's components include:

- 1) Participants' Roles and Responsibilities
- 2) Business Rules
 - Participation
 - Flow of Activity
 - Communication Protocol
- 3) Relationship between the PMO and Program Management Activities

I. Organizational Responsibilities and Relationships

The chart below (Figure 1.0) depicts the decision-making hierarchy and the relationship between the TRICARE Program and the projects. The roles and responsibilities of participants and organizations are detailed after the chart.

Figure 1.0
TRICARE Program Management Oversight



Once the overall direction and milestones are established by the Milestone Decision Authority (MDA), execution of the TRICARE Program operates as a “bottom up” activity – all execution decisions are made at the lowest appropriate level possible. Issues that cannot be resolved are elevated to the next level within the organization through completion. Ultimately, the MDA has the final decision authority for the TRICARE Program.

The titles and respective responsibilities are listed below:

Milestone Decision Authority (MDA)	The <i>TRICARE Milestone Decision Authority (MDA)</i> is the final authority for all TRICARE related activities. The MDA approves the advancement of a project from one phase to another. The MDA provides direction, oversight and final approval to all projects.
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TRICARE Executive Committee (TEC)	The <i>TRICARE Executive Committee (TEC)</i> serves as an advisory committee at the request of the MDA or the Deputy Executive Director. Its membership includes the Service Surgeons General. The TEC may serve as a sponsor or proponent for a project and as a liaison between Service constituents and the MDA, TRICARE Management Activity (TMA), and/or Deputy Executive Director.
--	---

TRICARE Deputy Executive Director	The <i>TRICARE Deputy Executive Director (DED)</i> is primarily responsible for oversight and management of the planning, integration, and coordination of one or more multiple projects that fall under TRICARE Program Management. Depending upon scope and complexity, projects may be assigned full-time to a Project Manager (PM) or Co-PMs by the TRICARE DED. The TRICARE DED is accountable to the MDA for delivering a quality deliverable project on schedule and within cost. He/she reports progress and issues regularly to the MDA. The DED determines which projects will require oversight and assignment under Program Management.
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Deputy Surgeons General (DSGs)	The <i>Deputy Surgeons General (DSGs)</i> serve as a first level advisory committee and review projects and timelines as presented by PMs. The DSGs also provide input from the Service perspective through the nomination of Service representatives and participants.
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Resource Management Steering Committee (RMSC)	The <i>TRICARE Resource Management Steering Committee (RMSC)</i> membership includes Senior Comptrollers from each Service component served by the Defense Health Program (DHP). The TMA
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Health Services Delivery Steering Group (HSDSG)	The <i>Health Services Delivery Steering Group (HSDSG)</i> is comprised of senior representatives from each of the Services and the TMA Chief of Staff. The group reviews updates from TRICARE Integrated Project Teams (IPTs) and ensures the respective DSGs are properly informed of TRICARE projects.
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TRICARE Management Activity (TMA) Directors	The <i>TRICARE Management Activity (TMA) Directors</i> are responsible for the oversight and management of the TMA directorates. The Directors are accountable for the performance of the PMs from their directorates and are responsible for IPT progress through reports from their respective PMs and IPT members. All TMA Directors track progress, milestone achievement and provide guidance to the PMs.
--	--

Program Management Office (PMO)	The <i>Program Management Office (PMO)</i> provides an approved program management model for TRICARE and adds structure and processes, where appropriate, to meet the execution and integration requirements of projects assigned to the TRICARE PMO. The PMO process was established to develop a centralized business approach using board concepts from the DoD 5000 series tailored for the TRICARE Program. This office provides staff support to facilitate issue resolution, monitor project development, and track timelines/milestones. Reports and updates are provided on a routine basis to the TRICARE DED to obtain concurrence. When appropriate, the PMO staff facilitates the integration of PMO projects to ensure all aspects of TRICARE projects are supportive and complementary.
--	--

Co-Project Manager (Co-PM)	The <i>Co-Project Managers (Co-PMs)</i> are appointed in writing by the DED. The Co-PMs are responsible for the planning, integration, management and execution of day-to-day activities associated with meeting the project mission, schedule, cost, and deliverables. They are ultimately responsible for the completion of mandatory and discretionary documents and activities, and reporting project progress to the DED on a regular basis. The Co-PMs coordinate issue resolution through the IPT appointed to the project. The Co-PMs determine the team composition, meeting frequency and strategic direction. Consultation with the Director, PMO is available as needed.
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PC consults with the Co-PMs on a regular basis to assist with the program’s day-to-day activities. PC support functions cease when IPT work is completed.

Integrated Project Team (IPT)	The <i>Integrated Project Team (IPT)</i> facilitates teamwork and collaborative decision making to generate recommendations related to the assigned project objectives. Each member represents a functional area or contributes subject matter expertise to meet project deliverables. Composition will be determined by the scope and complexity of the project, along with staffing needed to support the Co-PMs in the management of the project. Membership on the IPT consists of senior staff officers within the TMA Directorates, Services, Regional Offices, and other organizations as identified by the Co-PMs.
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Working Integrated Project Team (WIPT)	The <i>Working Integrated Project Team (WIPT)</i> is responsible for specific issue resolution as assigned by the Co-PMs. Potential issues are forwarded to the Co-PMs for dissemination to the WIPT chair. WIPTs are appointed and empowered by their work area and participate in resolving specific issues related to the PMO project. WIPTs may work a specific issue for the IPT and present a recommended solution and/or alternatives for IPT consideration and action. Informal WIPTs meet to work a specific issue and present a deliverable to the IPT Chair. This deliverable may be a recommendation to the group, a review of a policy or report, or other short-term task.
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Formal Working Integrated Project Team (WIPT)	The <i>Formal Working Integrated Project Team (WIPT)</i> is similar to an IPT in that the formal WIPT scope, length, and mission is approved by the TMA Directors and Deputy Executive Director, and a WIPT Project Officer (PO) is formally appointed. The PO requests membership nominations from Services, TMA, and/or external organizations (as necessary), facilitates teamwork and collaborative decision making regarding WIPT objectives, prepares core program management documentation, and provides leadership briefs at milestone decisions. A formal WIPT and an IPT differ in that a formal WIPT is a subordinate group to a pre-existing or Overarching IPT (OIPT) under leadership of the IPT Co-PMs due to integration of multiple, related missions or the dependency of objectives and deliverables. In the absence of the need for an Overarching IPT, this group would be defined as an IPT due to its scope. The WIPT PO coordinates and informs the IPT Co-PMs the forward progress of clearly defined WIPT deliverables/objectives.
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at various stages of delivery. These representatives are expected to serve as liaisons to their appointing organizations to provide updates and information to their leadership, as well as to coordinate feedback with the Director and Co-PMs at regularly scheduled intervals.

The MHS Patient Safety Project IPT is composed of a representative group of senior health policy experts from the Office of the Assistant Secretary of Defense for Health Affairs, TMA, military Services, Armed Forces Institute of Pathology, and the Uniformed Services University of the Health Sciences. Each IPT member has been identified as an essential participant for the success of the MHS Patient Safety Program set forth by the requirements in the NDAA 2001 legislation and Department of Defense Instruction 6025.17. Moreover, the IPT will work collaboratively with the Patient Safety Working Group (PSWG) and other agencies as appropriate to fully implement the MHS Patient Safety Program.

WORKING INTEGRATED PROJECT TEAMS (WIPTS)

WIPTs are working teams represented by cross-functional disciplines. IPTs form a WIPT to analyze a specific issue and recommend potential solutions when input from more than one organization or functional discipline is needed. The director or head of each agency or operation will typically appoint WIPT members. WIPTs should be formed to address a single issue and work on the issue for a shorter time period than an IPT.

There may be many WIPTs formed for a single project to address diverse issues. For example, when a new release of a managed care contract incorporates new information system requirements, the IPT may assign a WIPT to develop the cost estimate of the new requirement. A WIPT comprised of representatives from the Operations Directorate and the Information Management, Technology and Reengineering Office would work to define the functional requirements, develop a feasible technical solution, and develop a cost estimate.

At this time, the MHS Patient Safety Project IPT does not anticipate to employ any WIPTs. However, at the Co-PMs discretion a WIPT may be formed and established as needed.

II. BUSINESS RULES

The following rules guide the project participants through the day-to-day management and

All Government and TMA support contractor participants must execute a Confidentiality Statement (CS) prior to receiving any project management sensitive information. Integrated Project Team (IPT) members not privy to project management sensitive information are not required to sign the document. They must, however, receive a CS and acknowledge that they understand and will comply with the stated requirements. All new participants will be directed to the Co-Project Managers (Co-PMs) who will issue the CS. The original is kept by the Co-PMs, who will maintain the list of authorized participants.

Procurement sensitive documents will be provided on a need to know basis only. Procedures to protect this information must be observed at all times. Prior to all meetings, attendees will be screened against the list of authorized participants. In the event a participant does not abide by the stated requirements, the Co-PMs may remove that individual from this project.

Depending on the scope of the project, a Co-PMs or Deputy Project Manager (PM) may be assigned to provide additional management support. In this instance, the manager may delegate confidentiality documentation duties to the Co-PMs or Deputy PM (if applicable).

Attendance at IPT meetings is normally limited to IPT members and those directly invited by the Co-PMs.

There may be meetings with participation from other areas within TMA; core PMO staff that may consist of Government, military, and/or contractors; staff from the Surgeons General offices, or other designated offices. The Co-PMs may invite the individual(s) to attend specific meetings. The Co-PMs will be responsible for ensuring the invited personnel are instructed on the TRICARE PMO business rules regarding project sensitive information, if applicable. IPT members may also recommend to the Co-PMs that an individual or group attend a meeting(s) to assist in issue resolution.

IPT members should identify an individual from their organizations to serve as an alternate for those meetings they cannot attend. While an alternate will not be required to attend or participate in regularly scheduled IPT meetings and tasking, they will be responsible for complying with the rules identified in this Business Plan. In the event a discussion at an IPT meeting results in a vote, the alternate may provide input but may not serve as a voting member.

B. FLOW OF INFORMATION

**C. COMMUNICATION PROTOCOL
(FOR PROCUREMENT SENSITIVE INFORMATION ONLY)**

E-mail communication within the Health Affairs (HA)/TMA Network is secure for sensitive information and authorized provided that:

- The email has “Procurement Sensitive” legibly printed at the top and bottom of the communication;
- All recipients have a need to know and have agreed to the terms of the Confidentiality Statement;
- No recipient is located outside of the TMA Local Area Network ;

The transfer of documents and files sent to authorized participants outside of the HA/TMA network must be accomplished using traditional safeguarding measures such as approved Courier Services (i.e., Federal Express) unless a secure e-mail communication channel with encryption has by approved by the Co-PMs.

Any questions regarding these procedures should be forwarded to the Co-PMs who will resolve the issue.

**III. RELATIONSHIP BETWEEN PMO
AND PROGRAM MANAGEMENT ACTIVITIES**

Program Management activities will be coordinated by the PCs to ensure the successful completion of all initiatives identified for management and oversight by the PMO. PC Coordination of project management activities will eliminate duplication of effort between the multiple activities, share information, integrate Program Management projects, and secure the efficient production of identified deliverables. All activities will use a teamwork approach to identify issues, resolve those issues, and keep the deliverables on a schedule to meet established milestones.

IV. APPROVALS:

CAPT Frances Stewart, Co-Project Manager

Date

SAMPLE I - PROJECT MANAGEMENT PLAN

**SELF REPORTING TOOLS
PROGRAM MANAGEMENT PLAN**

REVISED DRAFT
January 2001

Purpose and Overview:

Revisions to this document are being made to reflect the new direction of the Self-Reporting Tools Program. The initial focus of this program, as depicted in the original version of this document, was to fix the paper-based HEAR v1 that is currently being used throughout the MHS. The new focus of this program moves beyond the paper-based HEAR and is looking at creating an integrated and modular approach for the collection, storage, study and use of all MHS self-reported information by use of an automated HEAR tool (v2.x) accessible by PC or the web. The TMA Directors and the DSGs approved this new program direction in November 2000. The efforts of this IPT aim to eliminate duplication and waste associated with the use of multiple self-reporting tools (SRT) across the MHS and to create a strategy to support MHS population health objectives and Healthy People 2010 population health programs.

Background:

The Health Enrollment Assessment Review (HEAR) v1.0 was developed in response to a request from TRICARE Region 6 to assess the patient population in that region. The Office of Prevention and Health Services Assessment (OPHSA) developed the self-administered, 82-item questionnaire. ASD (HA) Policy Memorandum of October 1996 established the HEAR 1.0 survey as the DoD designated instrument for health assessment and directs all Lead Agents to implement the HEAR Program. In addition, the Put Prevention Into Practice (PPIP) campaign developed by the U.S. Public Health Service's Office for Disease Prevention and Health Promotion requires that appropriate and comprehensive prevention services be provided to all patients based on their age, sex and risk factors. ASD (HA) PPIP Policy requires that all TRICARE prime enrollees participate in the HEAR Program by April 1999.

The current DoD standard self-reported health information tool is the paper-based HEAR 1.3, which is the Y2K-compliant version of HEAR v1.0. The HEAR was designed to establish baseline health status, identify enrollees in need of preventive services, assist with PCM assignment, identify health risk behaviors, predict resource utilization, and provide the PCM and medical managers with reports and tools to assist in health care management. The HEAR has failed to live up to its expectations due to inconsistencies in contractor administration, poor beneficiary compliance, lack of identified PCMs to receive the reports, and confusion about its purpose. The current automated version of the HEAR (v2.x) is a considerable improvement over the paper-based version, but it is

Objective:

The overall objective of this Program is to effectively deploy a standardized SRT throughout the MHS that meet the defined needs of the customers.

As defined by the Assistant Secretary of Defense for Health Affairs [ASD (HA)], the mission of the Health Enrollment Assessment Review (HEAR) is: to provide medical and behavioral information on active duty personnel and TRICARE Prime beneficiaries to primary care managers, MTF commanders, resource managers, TRICARE contractors, line commanders, lead agents, military service departments and the Department of Defense. This use of SRTs is central to the MHS strategy for Force Health Protection (FHP) and the TRICARE program through:

- (1) Establishing baseline and ongoing health status of our active duty members to monitor operational fitness;
- (2) Identifying TRICARE Prime enrollees requiring preventive health care services, assigning patients to a primary care level based on complexity of care required; classifying patients according to predicted level of resource utilization; and identifying patients with high risk behaviors who can benefit from intervention.

Scope:

The SRT/HEAR IPT has joined forces with IMT&R to support the objectives of the Health Care Quality Information and Technology Enhancement Authorization Act – Section 723. We are now collaborating with an independent research group from Yale university to evaluate the HEAR and the pre and post-deployment questionnaires for validity, reliability, and efficacy. Problem Knowledge Couplers (PKC) will be used as the interface to move data from these questionnaires to CHCS II. HEAR and pre and post-deployment modules have already been created. These modules function well in a stand-alone mode, can easily be web-enabled for remote usage, and preserve data for incorporation into CHCS II. A demonstration project is planned for rollout with CHCS II in 2001. The Yale group anticipates a long-term commitment to this initiative and is currently researching other MHS SRTs for incorporation into an enterprise-wide SRT strategy. Their commitment includes research of longitudinal self-reported information to assess health care outcomes and support of MHS population health objectives.

exposure, retirement, etc). These modules will be subsets of the full, comprehensive tool.

- Tailor modules to populations such as adolescents, Medicare eligible, reservists, high-risk military occupations. Enable continuation into retirement and VA health care.
- Enable data extraction to support activities such as PCM assignment and resource management.
- Facilitate intervention strategies to improve individual and MHS population health.
- Create a cell in the MHS Optimization and Population Health Support Center (MHS OPHSC) for ongoing support and improvement of SRTs, study of self-reported data, and feedback to MTFs, Commanders, Lead Agents, and MHS leaders on health status of our service members and TRICARE prime enrollees. Create an MHS/TMA hub but use regional population health offices and service preventive health activities as component parts of a virtual MHS support center.
- Establish a clinical data repository (CDR) and Master data repository (MDR) to collect self-reported information and marry it with clinical information to add to the patients medical record.

Program Strategy:

The major activities of the Program will be implemented in four phases:

Pre-Phase Re-Establishment of Mission Need: Move away from v 1.3 & establish another tool

Phase 0 Concept Exploration: Develop Alternative to HEAR 1.3
Roll out HEAR 2.x as stand-alone
Web-enable HEAR
Modules for smaller HEAR survey for readiness (PKC technology)
Coordinate with Yale research group on assessment of MHS tools
Examine CDR and MDR possibilities
Explore MHS OPHSC concept
Approval of Approach by PEO/MDA, DSGs - **MS I 11/00**

Phase I Program Definition and Risk Reduction: Develop Plan
Develop Functional Requirements
Develop Concept of Operations
Develop HA Interim Policy
Integrate Yale analysis and recommendations

MHS OPHSC business process formalization
Marketing and Training for HEAR 2.x
Approval for implementation by PEO/MDA, DSGs - **MS III 10/01**

Phase III Deployment and Operational Support
Establish SRT oversight in MHS OPHSC
Phased roll-out of HEAR 2.x
Transition out - **MS IV 12/01 - 1/02**

The Program will proceed through all of the phases ending with ongoing support for the finalized product(s) within the TMA. The basic tenets of Program Management as proscribed in DoD 5000 and Optimization and Integration will be adhered to.

Management Approach:

The management approach for the Self-Reporting Tools Program will follow a tailored version of the management model detailed in DoD 5000.2R, Mandatory Procedures for Major Defense Acquisition Programs (MDAPs) and Major Automated Information System (MAIS) Acquisition Programs. The DoD 5000.2-R management process is structured in logical phases separated by major decision points called milestones. The process begins with the identification of broadly stated mission needs and translates those needs into a stable, affordable, well-managed program.

At program initiation and after approval the mission need, the Program Manager (PM) will propose for consideration to the PEO/MDA: the appropriate milestones, the level of decision-making for each milestone, and the documentation for each. Changes and recommendations will be coordinated among the PEO/MDA, the Director of PM&I, and the Program Manager and incorporated into the Program Management Plan (PMP). This plan will be submitted to the PEO/MDA for final approval.

In addition to this structured, yet tailored approach, key tenets of the DoD 5000.2-R acquisition management model will be used to integrate essential cross-functional disciplines to optimize program decisions. The cross-functional IPT (stakeholders) will execute the program. When possible, the IPT will use a consensus decision-making process.

Migration Strategy:

Program Integration:

The Program Management and Integration Directorate is responsible for compiling and analyzing information from all of the TRICARE Programs. PM&I will build and maintain systems that will store all documents, schedules and data for all programs, enabling the Program Manager and Director, PM&I to:

- Identify opportunities for program collaboration when desirable
- Identify program's impacts on other TRICARE programs.
- Identify program's impacts on the overall TRICARE Program.

THE PROGRAM MANAGER REPORTS REGULARLY TO THE DIRECTOR, PM&I, AND PEO/MDA ON PROGRAM INTER-RELATIONSHIPS, SCHEDULE CONFLICTS, PROGRAM STATUS, ETC. WHEN NECESSARY, THE PM WILL INTERACT WITH PMS OF OTHER RELATED PROGRAMS TO ATTAIN CONGRUENCY OF EFFORT AND AVOID DUPLICITY.

IT IS ANTICIPATED THAT INTEGRATION WILL BE REQUIRED WITH THE CLINICAL INFORMATION TECHNOLOGY PROGRAM OFFICE (CITPO) TO ESTABLISH A CDR FOR SELF-REPORTED INFORMATION, AND IN THE FACILITATION OF FUNCTIONAL REQUIREMENTS AND DEPLOYMENT OF THE STAND-ALONE AUTOMATED HEAR. THIS IPT WILL ALSO WORK WITH THE EXECUTIVE INFORMATION DATA SYSTEMS (EIDS) OFFICE TO ESTABLISH FUNCTIONALITY WITH THE MDR TO RETAIN STATIC CLINICAL INFORMATION FOR USE BY VARIOUS AUTHORIZED ENTITIES THROUGHOUT THE MHS. ULTIMATELY, CHCS II WILL NEED TO BE FIELDED TO MAKE THESE FUNCTIONS FULLY OPERATIONAL.

Data Standards:

Health Insurance Portability Performance Act (HIPPA) standards may apply to SRTs because they link a name to patient data. If the current proposed standard is adopted by Congress, this will mean when data is transmitted over a Wide Area Network or the web, it must be encrypted and must have a digital signature attached at both sending and receiving ends. Proposed standards after 2000 will be Advanced Encrvption Standard

SRTs have the potential to impact a wide variety of MHS wide and service specific systems that must be evaluated for impact including CHCS, CHCSII, PHCA, DEERS, CEIA, SAMS, HRA, etc.

Performance Metrics:

Performance measures to track the success of this Program will be established. Vital to the success of the Program is incorporating metrics on the MHS Report Card. Performance measures will be directly tied to the objectives and requirements of the program and will be designed to evaluate program effectiveness, address appropriate organizational levels, identify trends and address or incorporate civilian benchmarks. Other issues include protection of respondents' privacy and assurance that regulatory guidance regarding implementation of surveys is met. These performance parameters will be developed and monitored by the SRT oversight entity of the MHS Population Health Support Office.

Resource Requirements:

Funding will be required for the rollout of the automated HEAR and its modular components in a standalone format. Development of the automated HEAR and the modules is already funded, and largely complete. Upon review of the functional requirements, IMT&R may decide to fund this effort and task it through one of the functional business areas within TMA, such as CITPO. If not, funding will need to be sought elsewhere and this effort will need to be contracted out via D/SIDDOMS or a similar contracting vehicle. Additional resources will also need to be sought for the MTFs to support the administration of the automated HEAR, i.e. personnel, computers, etc.

Risk Assessment/Technical Risk:

HEAR 2.x will initially be deployed as a stand-alone system, thus it will not require CHCS II to operate. However, until CHCS II is fielded, connectivity to a CDR and the MDR will be needed to store the HEAR data for population health assessment and as a reference for a person's medical record.

Patient confidentiality is the key risk in the use of the HEAR or any other SRT. A TMA-approved Privacy Act Statement for HEAR 2.x will need to be strictly adhered to, particularly for web enablement. The developers of the HEAR software will need to

incorporated into plans to implement a unified self-reporting tool throughout the MHS. Any recommendations made that run contrary to the current roll-out plan could delay progress in accomplishing the mission of correcting the current problems associated with the paper-based HEAR.

Cost Risk:

Resources need to be identified for Program Management at the TMA level. This includes personnel and funding resources to support activities under the control of the PM and the subsequent risk mitigation efforts. Resources for ongoing oversight of the HEAR program after the IPT has completed its charter will also need to be adequately assessed.

Contract modifications will be needed to relieve the MCSCs of their current obligation to collect and process the paper-based HEAR 1.3. Monies re-cooped from these contracts will result in savings to the government, but additional costs will need to be considered for the additional resources needed for the MTFs.

Consideration must also be made for costs tied to other SRTs currently in use or development that may be discontinued as a result of SRT integration or the recommendations made by the Yale Research Group upon completion of their study.

Schedule Risk:

Schedule risk will be identified with schedule slippage within the program life cycle and in related programs. Mitigation strategies including schedule metrics, use of incremental development and delivery activities, and application of realistic estimation processes for planning activity program will be utilized.

Approvals:

_____ IPT Program Manager	_____ Date
_____ TRICARE PEO	_____ Date

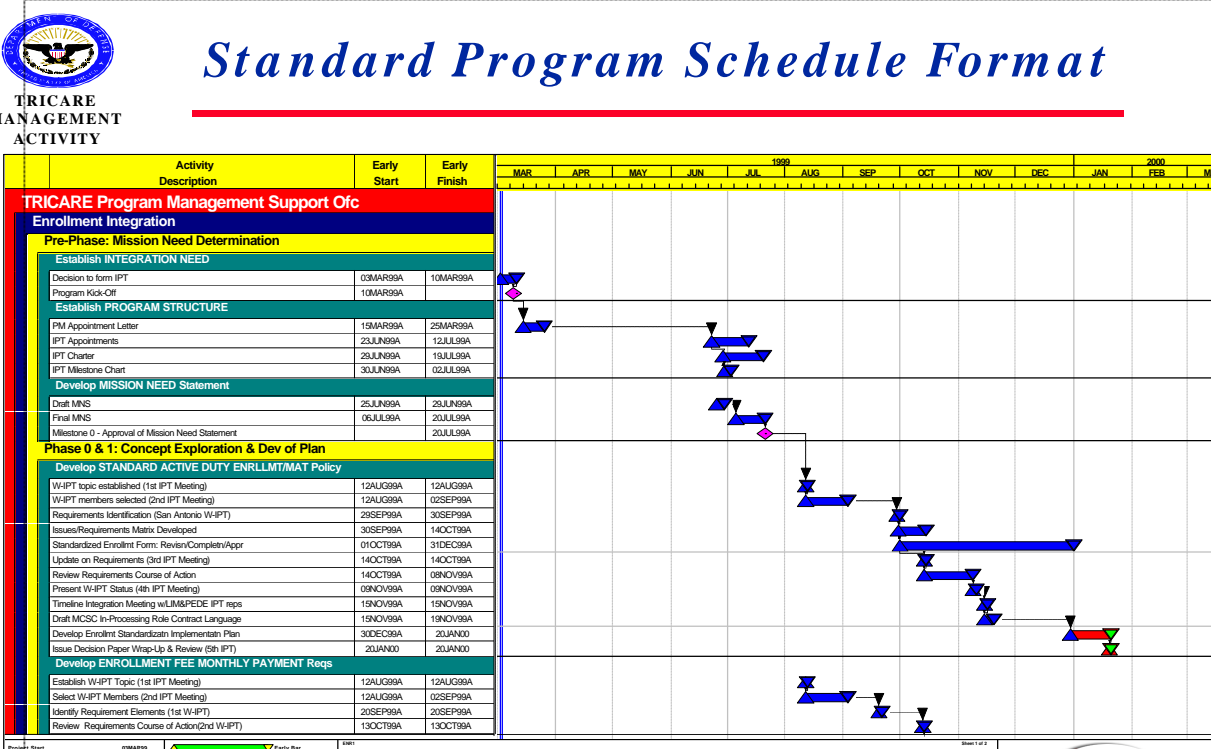
Other Supporting Document

Below are documents that may be used in addition to the core documents. The termination of need for these documents is at the discretion of the PM.

7.1 Primavera v3 Schedule

The Primavera v3 (P3) scheduling application is the DoD standard for scheduling cases, tasks and milestones of a project. Each project is typically printed in a Gantt chart format (Sample I) which will depict the current status of the project and the repercussions of any subsequent delays. Input from the functional components is vital in developing the schedule to ensure adequate time intervals are established. Once the schedule baseline is set, the P3 tool is primarily for the use of the PM and PC to assist in the management of the project.

EXAMPLE 1 - PRIMAVERA v3 (P3) SCHEDULING CHART



SECTION 4

Reporting Requirements

- ❖ *Initial Brief to Deputy Executive Director*
- ❖ *Program Management Office Kick-off Meeting*
- ❖ *Concept Approval Briefing*
- ❖ *Integrated Project Team Review Briefing*
- ❖ *Milestone Approval Briefing*

4.1 Initial Brief to Program Executive Officer

The PEO and Director, PMO Office will meet with the newly appointed PM to discuss the project selected for program management. This meeting provides an opportunity to discuss project issues such as IPT membership, project scope, project funding, technological alternatives and possible outcomes of the program management process.

4.2 Program Management Office Kick-off Meeting

The Director of PMO and the PC will meet with the newly appointed PM to discuss the PMO process. This meeting will provide the PM with an understanding of the purpose of PMO, the tailoring of DoD 5000 to TRICARE and the roles and responsibilities of the Director of PMO Office, PM and PC. Funding availability and constraints, IPT membership, structure and responsibility, and the reporting process will also be reviewed.

The PMO Director will provide an additional orientation for the PM that includes:

- Selecting IPT members and requesting appointments to the IPT;
- Initiating project implementation strategies;
- Reviewing requirements for the Mission Needs Statement and Project Management Plan;
- Reviewing project priorities and kicking off the project;
- Identifying functional requirements, budgetary requirements and data quality elements as applicable.

4.3 Concept Approval Briefing

Once the PM has decided on a course of action and established a plan for the Mission Needs Statement and a plan to initiate the program management process, a meeting will be scheduled with the DED/TMA Directors six to eight weeks after the project “kick-off.” This brief is to review a concept of operation that includes project definition, goals and progress. Suggested items are:

4.4 Integrated Project Team Review Briefing

The PM is required to periodically brief the status of the IPT to the DED, the TMA Directors and Service representatives. The purpose of these briefings is to update all the stakeholders on the status of the project. The brief should be identified as informational or as a request for a decision. Briefing slides are due to the PMO one week prior to the actual brief for advance distribution. The PM must have an IPT Review brief prior to briefing the DSGs. Topics that should be discussed are:

- Progress based on mission
- Timeline
- Funding requirements
- Roadblocks and/or issues
- Next steps and decision points

These briefings are set up by the PMO Office. The PMO will also give the PM guidelines on the standard briefing format.

4.5 Milestone Approval Briefing

When an IPT has approached a milestone, a meeting will be scheduled for the PM to brief the progress made with the project. Milestone briefings are presented to the DED and DSGs. This briefing must be clearly identified as a milestone brief, state accomplishments in the current phase and request permission to move to the next phase. Decision points must also be highlighted during the brief and presented for additional direction, approval or disapproval. The PM should provide the necessary document(s) to be signed as approval to go to the next phase or step. **(See Section 3 on Milestone Chart)**

SECTION 5

Change Management

- ❖ *Definition of Change Management*
- ❖ *Roles & Responsibilities*
- ❖ *Process*
- ❖ *Planning, Programming & Budgeting System and Project Funding*

5.1 Definition of Change Management

Change Management (CM) is the process by which changes are made to the TRICARE baseline. It begins with a change request proposal and ends when the implemented change becomes part of “normal business”. These changes include new services, expansion of the current benefit, optimization efforts and administrative updates. Initiatives can be driven by Congressional legislation, professional/community standards of care, or contractual obligations. The primary navigator of the CM process is the PM. He/She must ensure the project successfully progresses through the TRICARE Program Management Organization model and its inherent milestone decisions. The Program Management & Integration Office facilitates the TRICARE change management process. Frequently Asked Questions (FAQs) about Change Management can be found in **Appendix D**.

5.2 Roles and Responsibilities

Below are roles and responsibilities of various individuals and groups in relation to the change management process.

Change Management Board (CMB) The TRICARE **Change Management Board (CMB)** is chaired by the TMA Deputy Executive Director/PEO and serves as the executive level board responsible for approving new changes. The Services' Deputy Surgeons General and the Joint Chief Staff (JCS) J-4 Medical Officer are on the CMB. The CMB acts as the Milestone Decision Authority (MDA) for the TRICARE Program. The scope of responsibility includes the continuous monitoring of TRICARE changes, and the review, approval and prioritization of TRICARE benefit changes that represent a policy shift or fiscal impact.

Deputy Executive Director (DED) The TRICARE **Deputy Executive Director (DED)** is ultimately responsible for implementation of all TRICARE projects and related managed care support contracts (MCSCs). He/she approves projects for concept evaluation and chairs the Change Management Board.

(MTFs). On a semi-annual basis, the group prioritizes newly developed project changes and requirements for implementation and makes recommendations to the Change Management Board.

Resource Management Steering Committee (RMSC)	The TRICARE Resource Management Steering Committee (RMSC) membership includes Senior Comptrollers from each service component served by the DHP. The TMA Deputy Director for Resource Management chairs the committee. In coordination with the HSDSG, the RMSC makes project funding recommendations. The group also reviews cost estimates submitted with change packages.
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Regional Management Team (RMT)	The TRICARE Regional Management Team (RMT) consists of technical and contracting personnel from DoD/Regional Operations, TMA/Acquisition Management & Support Directorate, the Lead Agent Staff, and the MCSCs. The team is responsible for implementing project changes as approved by the CMB and the TRICARE PEO.
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Program Management Office (PMO)	The TRICARE Program Management Office (PMO) facilitates the TRICARE change management process. It coordinates support staff for Project Managers, maintains master status listing of all projects and coordinates all executive level briefings related to project updates. The PMO Office is the primary liaison between the DED and Project Managers.
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Project Manager (PM)	The TRICARE Project Manager (PM) is accountable and responsible for the day-to-day activities of his/her project and for ensuring the project progresses through the change management process. Required tasks include the completion of mandatory and discretionary documents, certification of cost estimates, coordination of funding requests and the appropriate briefing of decision making bodies. He/She is required to brief
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and works in close coordination with the PM. The Change Cycle Manager is lead facilitator for the pricing IPT.

5.3 Process

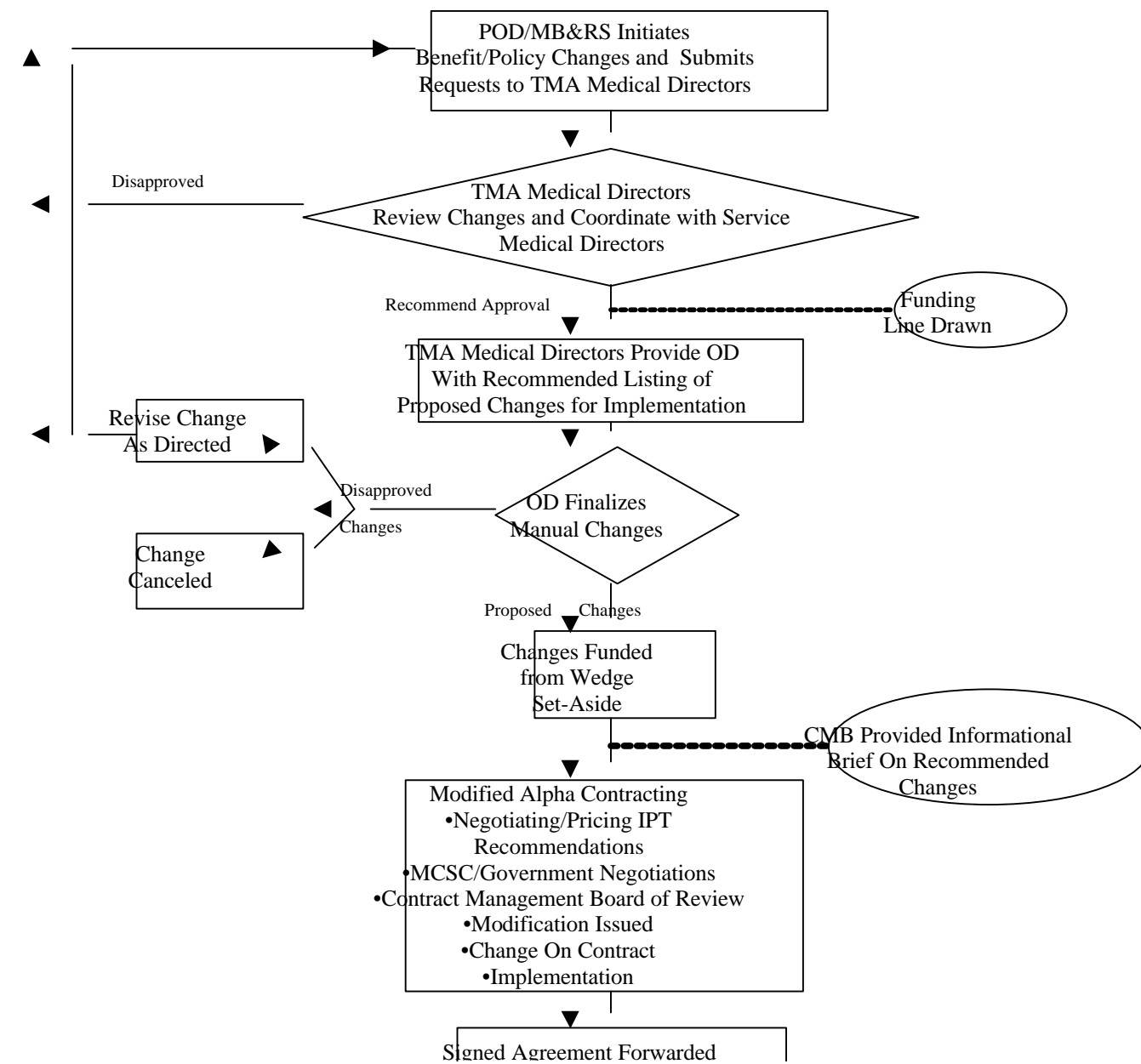
Changes to the TRICARE baseline are categorized as non-discretionary or discretionary. Approval processes are flowcharted in **Figures 2 and 3**. Three percent (3%) of the value of the managed care support contracts is budgeted on an annual basis for changes to the managed care support contracts. This budget is commonly referred to as the "wedge". Non-discretionary changes include medically necessary standard of care issues and recurring required operational changes. Non-discretionary changes are initiated by the Operations Directorate (OD), TMA Medical Directors or the Services. Coordination with the Service Medical Directors may be necessary. Due to the urgent and/or unavoidable nature of these changes, funds have been set aside for implementation. The HSDSG, RMSC and CMB are provided informational briefings on non-discretionary items actioned.

Discretionary changes encompass all other items. These changes or projects are facilitated within the PMO process and therefore go through the three phases of the Change Management process. The phases are:

- Requirements Generation Phase
- Contracting/Pricing Phase
- Change Implementation Phase

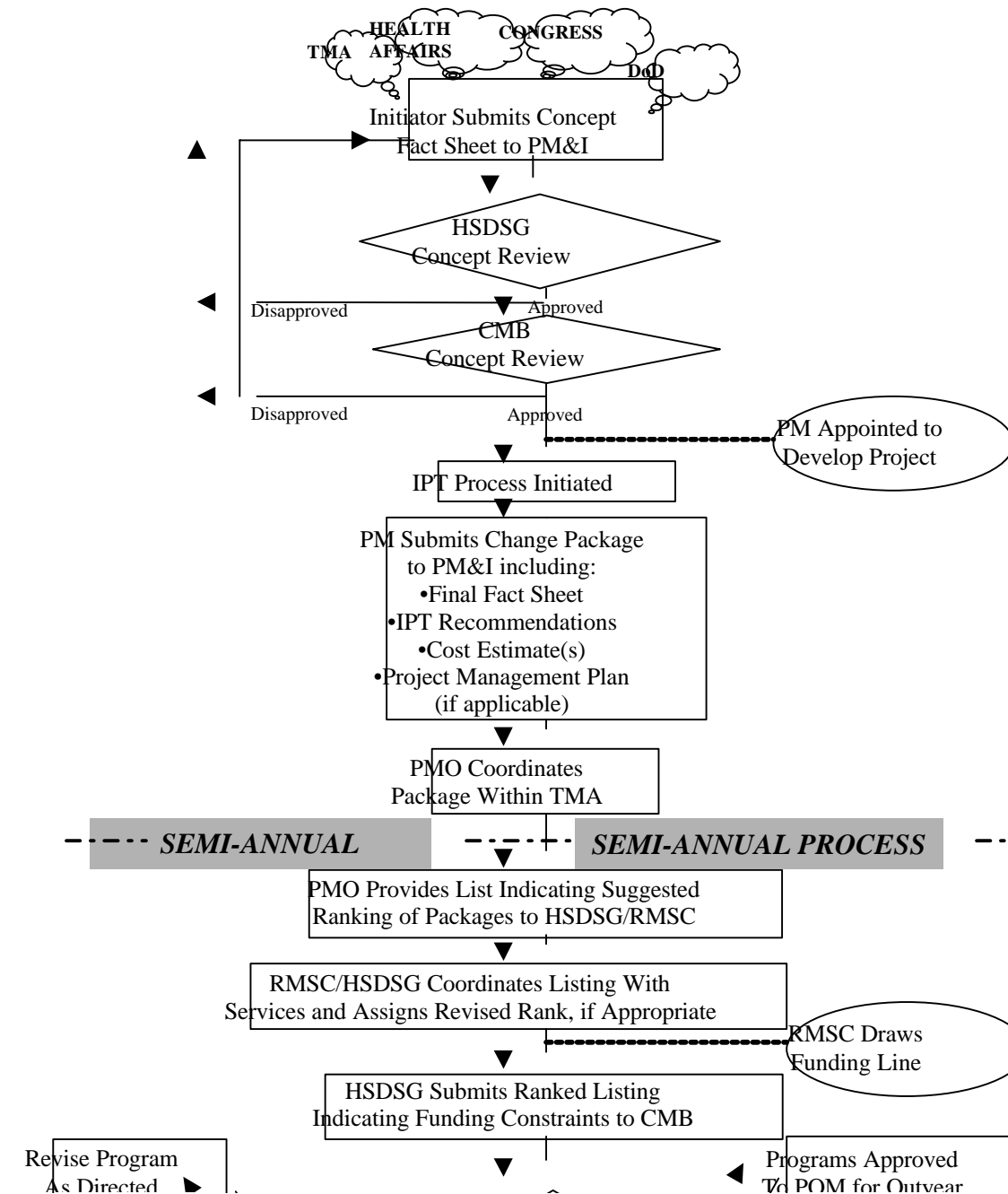
**CHANGE MANAGEMENT PROCESS
for Non-Discretionary Changes**

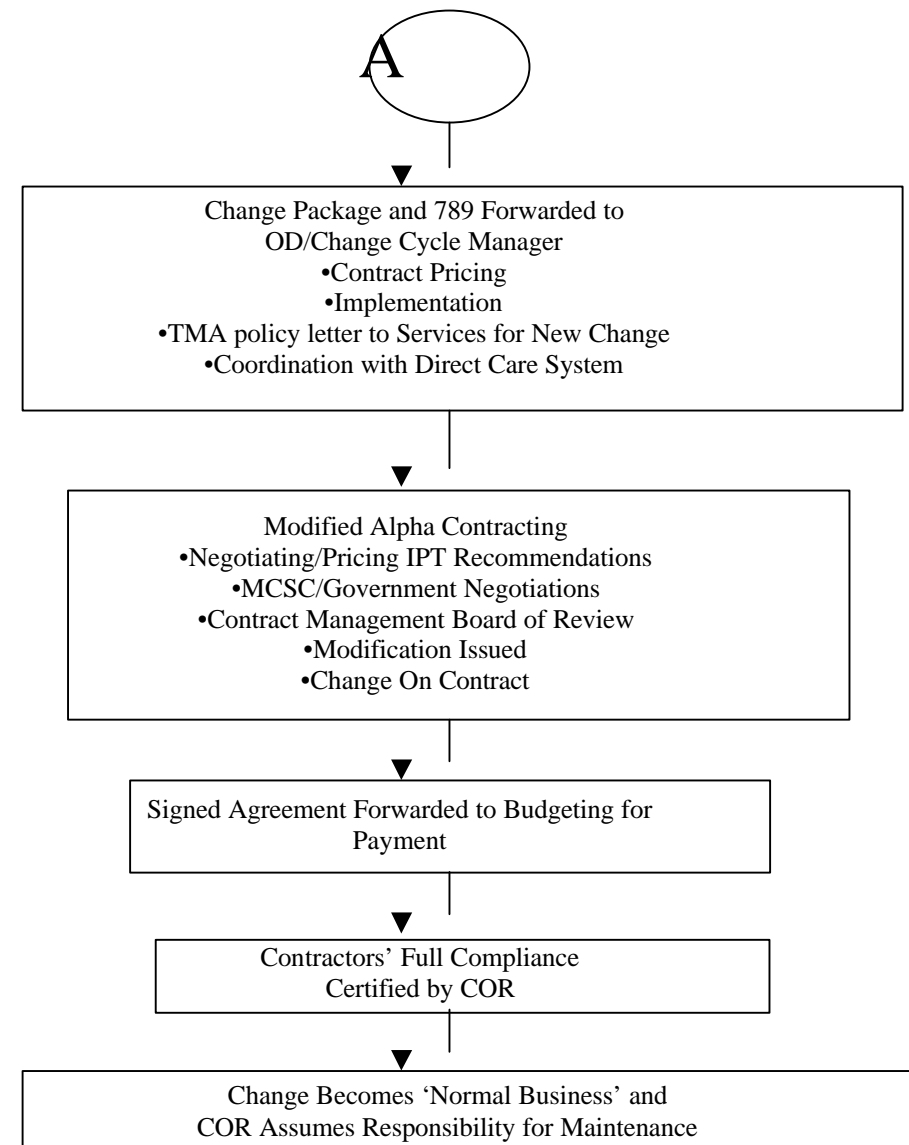
Figure 2



**CHANGE MANAGEMENT PROCESS
for Discretionary Changes**

Figure 3





5.3.1 Phase I: Requirements Generation Phase

The requirements generation phase entails the identification and development of project needs. This phase may include policy development and approval to definitize the scope of the requirements. Appropriate stakeholders are pulled together to review the issues, assess alternatives and formulate costs. Phase stages include concept approval, project requirements & cost estimation and change package approval.

5.3.1.1 Concept Approval Stage

The change management process begins with the approval of the concept by the PEO and HSDSG. To obtain approval the project initiator must submit a Project Fact Sheet to the PMO. The Fact Sheet includes a brief description of the proposed project and a preliminary cost estimate. Fact Sheet templates may be downloaded from the TRICARE website <http://www.tricare/pmo/info/templates.html>.

5.3.1.2 Project Requirements & Cost Estimation

Upon approval of the concept, a Project Manager (PM) is assigned to develop and refine project requirements. Using the Program Management Office process, the PM forms an IPT consisting of personnel representing pertinent functions and directorates. After a general framework is developed, the PM will work through the Contracting Officer (CO) to bring in the managed care support contractor (MCSC), a third party independent estimator and government contracting and pricing staff. Through a series of meetings the team will refine project requirements and develop a rough order of magnitude (ROM). Additionally, the third party independent estimator will submit a cost estimate. Based on the ROM and the estimate from the independent third party, the PM determines the final costs and life cycle cost analyses to be included in the change package and recommended to the CMB.

5.3.1.3 Change Package Approval

The developed change request and supporting documentation is submitted as a package to the PMO. At a minimum, the change package must include a

optimization efforts and funding availability. The RMSC plays an integral role in helping the HSDSG balance these needs by delineating fiscal limitations and determining the Service fiscal splits. HSDSG will also solicit comments from the Services.

The HSDSG prioritized listing indicating fiscal constraints, i.e. the fiscal line, is then forwarded to the TRICARE CMB for review. If approved, the CMB will authorize the Resource Management (RM) Directorate to commit funding. All approved change packages including a completed funding document (Form 789) are handed over to the assigned OD Change Cycle Manager to begin implementation for that semi-annual cycle. Although the PM retains ultimate responsibility for the program's implementation, the focal point of activity transfers to the Change Cycle Manager. If a project is not approved for implementation during the cycle it was submitted, the PMO Office will contact the PM regarding required action. The PM will be required to provide updated cost information and submit documents for the Planning, Programming and Budgeting System (PPBS) and Program Objective Memorandum (POM) process described in **Section 5.4** of this Guide.

5.3.2 Phase II: Contracting/Pricing Phase

The Contracting/Pricing Phase uses the team approach of alpha contracting principles. Alpha contracting is a concurrent process that results in a bilaterally negotiated supplemental agreement. (See **Appendix C** for more information on alpha contracting.) It is imperative that the PM stay in close contact with the Change Cycle Manager during the Contracting/Pricing Phase. The PM must be constantly aware of the project status and respond swiftly to any Change Cycle Manager requests. Delays may threaten the contracting window, cause significant difficulties in negotiations and subsequently result in the failure of the program's implementation.

The consolidated technical requirements are submitted to Contract Management who initiates a Pricing IPT with each MCSC. Simultaneously, the government will conduct evaluations through audits, technical reports, etc. As each area has been settled, it is written into the proposal and negotiated. Prior to execution of the modification or supplemental agreement, the CO must present the outcome of all negotiations valued over \$500,000 to the Contract Management Board of Review. Afterwards, the completed change package can be issued on a

5.3.3 Phase III: Change Implementation Phase

Upon receipt of the modification, the contractor will sign the necessary documents and begin implementation. When the signed modification is returned to Contract Management, it is certified and sent to Budgeting for payment. After the MCSC becomes fully compliant with the change to the contract, responsibility is transferred to Contracting Officer Representatives (CORs) for ongoing monitoring, quality assurance and surveillance. The change is now 'normal business' and falls within the auspices of the CORs' contract maintenance duties.

5.4 Planning, Programming & Budgeting System and Project Funding

The Planning, Programming & Budgeting System (PPBS) is the process by which TRICARE allocates project funding. The PM must ensure projects are approved by the CMB in time to be included in the appropriate budget cycle. The Resource Management directorate should be contacted to obtain dates on when submissions are due. It may also be necessary for the PM to update project costs if a project is approved for implementation in a fiscal year (FY) other than was originally planned.

With FY0 being the current year, PPBS budget vehicles are

FY Budget Impacted	Type	Development Schedule (New Budget)	Update Schedule (Revise Existing)	Modification Document
FY0	Wedge	Current FY	NA	NA
FY1 – FY2	Budget Estimate Submission (BES)	Every year	NA	Program Budget Decision (PBD)
FY3 – FY6	Program Objective Memorandum	Every even year	Every odd year	Program Decision Memorandum

SECTION 6

Resource Funding

- ❖ *Program Management Office Funded Activities*
- ❖ *Project Budget Development*
- ❖ *Business Case Analysis*
- ❖ *Program Objective Management Submissions*
- ❖ *Budget Estimate Submissions and Execution
Year Requirements*
- ❖ *Contracted Advisory Assistance Services &
Non-Contracted Advisory Assistance Services
Requirements*

6.1 Program Management Office Funded Activities

The PMO provides the PM with several types of resources.

- Project Coordinator (support personnel)
- PMO website development
- Office automation support
- Primavera Schedule development and tracking

All other support must be funded from the PM's project budget. If any questions arise regarding the activities funded by PMO, contact the Director, Program Management Office for clarification.

6.2 Project Budget Development

The PM is responsible for identifying staffing and budget requirements for the assigned project. There are different funding requirements for which the PM is responsible for budgeting.

- Managed Care Support Contract changes
- Direct care impact of changes
- Project staffing
- Other direct costs (including DEERS support, IM/IT changes, etc.)

For the PM to be accountable and have leverage to keep the project on track, he/she needs to be responsible for preparing, programming, defending and executing a budget.

Each new project needs to submit a budget plan covering the duration of the project. The budget plan should include staff support and other direct costs (ODCs). The ODCs may be for expenses related to meetings, materials, equipment, speakers, IT system support, technical solutions, etc.

The PM should not direct implementation of a project until the project plan is approved and resources are identified. This includes efforts internal to DoD such as Defense Manpower Data Center - Defense Enrollment Eligibility Reporting

6.3 Business Case Analysis

When a project is being developed for approval, as many options as possible should be defined and priced out. The business case analysis should include

- Impact of not implementing the project
- Minimal requirements to meet potential legal liabilities
- Implementation with limited resources
- Implementation with optimal or full requirements
- Recommended project

All decision briefings should include this business case analysis and be coordinated with the Resource Management Directorate in advance.

6.4 Program Objective Memorandum Submissions

Every year TMA is responsible for submitting a Program Objective Memorandum (POM) which in turn means each PM must submit a POM Fact Sheet (**Appendix E**).

POM development -

- Six-Year Long Range Budget - Covers objectives, planned activities and cost of each project
- Developed every two years (even years)
- Updated every second year (odd years)
- First two years of the POM will later be translated into the Budget Estimate Submission (BES)

6.5 Budget Estimate Submission and Execution Year Requirements

If a project is not resourced in the POM or requirements grow significantly above the approved project funding, the PM will be required to update the Project Fact Sheet for consideration in the BES.

Should the project have any unfunded requirements in the year of execution, the PM must brief the Resource Management Steering Committee and other TMA

6.6 Contracted Advisory Assistance Services & Non-Contracted Advisory Assistance Services Requirements

Each TMA Directorate is responsible for budgeting on an annual basis for Contracted Advisory Assistance Services (CAAS) and non-CAAS requirements. In turn each PM is responsible for submitting any CAAS or non-CAAS requirements to his/her respective Directorate. The assigned Project Coordinator is capable of assisting in the development of necessary documents, i.e. fact sheets for each project.

CAAS are defined in the DoD Directive 4205.2, February 10, 1992 as:

Services acquired by contract from non-governmental sources to support or improve organization policy development, decision-making, management and administration, or to improve the effectiveness of management processes or procedures.

CAAS may take the form of information, advice, opinions, alternatives analyses, evaluations, recommendations, training, or technical support. CAAS cannot be used for inherently governmental functions.

Non-CAAS requirements (DoD Directive 4205.2) include but are not limited to:

- Routine maintenance of systems, equipment, and software; routine administrative services; printing services; and direct advertising (media) services
- ADP and/or telecommunication functions and related services
- Clinical & medical services for direct healthcare

Funding for a project involving the following items should be addressed within each project budget, through the CAAS and non-CAAS process and coordinated with the PM's Directorate Budget POC.

- Staff extender support
- PC travel in support of the project
- Software or equipment purchases

Generally, the Project Manager should provide written justification and proof of funding availability more than two weeks prior to the desired travel date so that the most economical travel arrangements (e.g. plane tickets, hotel reservations, rental car) can be made.

Contract personnel are not allowed to reserve Government rates for air travel. However, if a Government invitational travel order (**Sample J**) is available, Government rates for hotel accommodations and other forms of travel (e.g. train, bus, car) may be available.

Contract personnel are entitled to per diem compensation as listed at the following GSA website: www.dtic.mil/perdiem.

SAMPLE J - TRAVEL ORDERS

Health Affairs Letterhead

<Contractor Personnel Name>
<Contractor Personnel Home Street Address>
<Contractor Personnel City, State, Zip Code>

Dear <Mr./Ms. Last Name>

You are invited to travel from <City, State> on <dd MM yyyy>, to <City, State> and return to <City, State> on or about <dd MM yy> for approximately <enter number of days> days of travel. The purpose of the travel is <enter purpose of travel> for the <enter project name>.

Travel by rail, military aircraft, commercial aircraft is limited to the most economical accommodations to satisfy mission requirements, as may be determined by the appropriate transportation officer and travel by privately owned conveyance at the rate of 34.5 cents per mile is authorized. Reimbursement for mileage by privately owned automobile will not exceed the cost of travel by the usual mode. Government rate rental care is authorized.

While en route and away from your home or place of business on the mission, your actual transportation expenses, including reimbursement for transportation not furnished in kind will be paid including per diem in lieu of subsistence in accordance with Volume 2 of the Joint Travel Regulations. Receipts and ticket stubs will be required to substantiate your claims for costs of transportation and subsistence for items in excess of \$25.00. Address any inquiries regarding this travel order to <enter name of Project Manager> at <enter phone number>.

Submission of a travel claim is required within 15 days after completion of travel. Three copies of this invitational travel order must be attached to the travel claim when submitted. Approval under authority of DODD 5118.3. Travel claim is to be submitted to Ms. Sharon Edmonds, 5111 Leesburg Pike, Suite 810, Falls Church VA 22041

SECTION 7

Appendices

❖ *Appendix A: Letter Instructional Templates*

A-1: Project Manager, Co-Project Manager & Deputy Project Manager Appointment Letters

A-2: TMA Directorate & Service Representative Integrated Project Team Appointment Letters

A-3: Lead Agent Representative Integrated Project Team Appointment Letter

❖ *Appendix B: Core Document Instructional Templates*

B-1: Mission Needs Statement

B-2: Program Management Office Business Plan

B-3: Project Management Plan

❖ *Appendix C: Alpha Contracting*

❖ *Appendix D: Change Management Frequently Asked Questions*

❖ *Appendix E: Program Objective Memorandum Fact Sheet*

❖ *Appendix F: Integrated Project Team Charter Instructional Template*

Appendix: A-1
Project Manager, Co-Project Manager
and Deputy Project Manager Appointment Letters

MEMORANDUM FOR <Title of Appointed PM >

SUBJECT: Project Manager Appointment for <Name of project> Integrated Project Team

You are hereby appointed the Project Manager (PM) for <Name of project>Integrated Project Team (IPT). The Department of Defense Regulation 5000.2-R and the TRICARE Program Management Directorate (PMD) User's Guide will assist you in your duties and responsibilities. Copies of these documents are available at www.tricare.osd.mil/pmo. <insert the global mission of this project (1 sentence)>.

As the TRICARE PM for the <Name of project> you are responsible and accountable for coordinating the day to day activities of the project and ensuring that the project progresses satisfactorily through the tailored TRICARE PMD model. The PM periodically reports status and progress to the TRICARE Deputy Executive Director (DED).

As the <Name of project> PM you are specifically responsible for:

- serving as the Chair of the <Name of project> IPT;
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE DED;
- briefing the IPT recommended project schedule to the TRICARE DED for approval;
- providing assessments of project status and risk reporting variances to the TRICARE DED;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- ensuring that the appropriate stakeholders are actively engaged in the project;
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment expires when <add specific information regarding when the project will end> or, at the request of the TRICARE DED.

MEMORANDUM FOR <Title of Appointed Co-PMs >

SUBJECT: Co-Project Manager Appointment for <Name of Project> Integrated Project Team

You are hereby appointed the Co-Project Manager (Co-PM) along with <Other Co-PM's name> for <Name of Project> Integrated Project Team (IPT). The Department of Defense Regulation 5000.2-R and the TRICARE Program Management Office (PMO) User's Guide will guide you in your duties and responsibilities. Copies of these documents are available at www.tricare.osd.mil/pmo. <Insert the global mission of this project (1 sentence)>.

As the TRICARE Co-PM for <Name of Project> you are responsible and accountable for coordinating the day to day activities of the program and for ensuring that the program progresses satisfactorily through the tailored TRICARE PMO model. The Co-PMs periodically report status and progress to the TRICARE Deputy Executive Director (DED).

As the <Name of Project> Co-PM you are specifically responsible for:

- serving as the Co-Chair of the <Name of Project> IPT;
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE DED;
- briefing the IPT recommended project schedule to the TRICARE DED for approval;
- providing assessments of project status and risk reporting variances to the TRICARE DED;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- ensuring that the appropriate stakeholders are actively engaged in the project;
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment expires when <add specific information regarding when the project will end> or, at the request of the TRICARE DED.

MEMORANDUM FOR *<Title of Appointed Deputy>*

SUBJECT: Deputy Project Manager Appointment for the *<Name of Project >* Integrated Project Team

You are hereby appointed the Deputy Project Manager (DPM) *<Name of Project>* Integrated Project Team (IPT). The Department of Defense Regulation 5000.2-R and the TRICARE Program Management Office (PMO) User's Guide will assist you in your duties and responsibilities. Copies of these documents are available at www.tricare.osd.mil/pmo. *<insert the global mission of this project (1 sentence)>*.

As the TRICARE DPM for the *<Name of Project>* you are responsible and accountable for coordinating the day to day activities of the project and ensuring that the project progresses satisfactorily through the tailored TRICARE Program Management model. The Project Manager (PM) and DPM periodically reports status and progress to the TRICARE Deputy Executive Director (DED).

As the *<Name of Project>* DPM you are specifically responsible for the following when the PM is not available:

- may be requested to serve as the Chair of the *<Name of Project>* IPT periodically;
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE DED;
- briefing the IPT recommended project schedule to the TRICARE DED for approval;
- providing assessments of project status and risk reporting variances to the TRICARE DED;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment expires when *<add specific information regarding when the project will end>* or, at the request of the TRICARE DED.

Appendix A-2:
TMA Directorate and Service Representative
Integrated Project Team
Appointment Letters

MEMORANDUM FOR DEPUTY SURGEON GENERAL OF THE ARMY
DEPUTY SURGEON GENERAL OF THE NAVY
DEPUTY SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Request for Appointment of Integrated Project Team Representative for the
<project name>

Your support is requested in the development and implementation of deliverables for the TRICARE Management Activity (TMA), <name of project> Integrated Project Team (IPT). This team will <Insert statement on purpose of project>.

As the TRICARE Deputy Executive Director, I have directed the formation of an IPT to be comprised of representatives from the Services and functional areas within the TRICARE Management Activity (TMA). The IPT shall work collaboratively to address all issues regarding <name of project>.

I request that you appoint an individual from your Service to serve on this IPT. The individual should have the requisite authority and expertise to speak for your functional or operational area considering the project's scope. The IPT begins <Month & Year>, and expires upon <identification of deliverables – project end>. The duration of the IPT is estimated to be approximately <months>. It is desired for continuity purposes that the person appointed be able to serve throughout the development and implementation of the improved processes.

I have attached a sample of an appointment memorandum for your guidance. The appointment memorandum should clearly state the expectations, responsibilities and authority of your representative. Please forward a copy of your appointment memorandum to me by two weeks from the date of this memorandum. If you have any questions, please contact <project manager>, Project Manager, <project name>, <phone> or by email at <email address>.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

Attachment:
Sample IPT Appointment Memorandum

SAMPLE

MEMORANDUM FOR (FILL IN)

SUBJECT: Expectations and Responsibilities of Integrated Project Team Members

1. I have nominated you to serve as the (Branch of Service) Medical Department representative on the (Fill-in) Integrated Project Team (IPT) that has been formed by the TRICARE Deputy Executive Director under the supervision of the Program Management Office, TRICARE Management Activity (TMA). This appointment identifies you as a functional expert on the matters the IPT is addressing.

The purpose of this memorandum is to let you know my expectations of you as an IPT member. First, I expect you to provide the IPT your well thought out functional opinions of the issues. Second, you are the (Service) action officer for the issues of the IPT you support. I expect you to fully staff this action. You are responsible for keeping the appropriate staff members informed of the IPT's progress and potential impacts. Coordination will prevent surprise when HA/TMA publishes a policy or begins a Project related to your IPT. Finally, you are responsible for keeping me and your supervisor informed on the status of your IPT by reporting to me through your appropriate chain of command using enclosure (1). Accomplishing this process in a timely manner will speed formal HA/TMA staffing within our department.

2. There is a limitation concerning your role as an IPT member. The Project Manager may interpret your opinions to be the (Service) position on a particular issue. The limitation is that your opinions are functional ones until the (Service) leadership approves a position. You must anticipate the requirement for a (Branch of Service) position and act to ensure a timely decision.

3. Your role in this process of managing complex and dynamic issues is very important. I look forward to seeing your work on these significant issues. Any questions you have regarding your responsibilities or limitation should be addressed to (fill in) who may be reached at (telephone number) or email:

SAMPLE

INFORMATION PAPER

Code

Date

SUBJECT: To Provide a Status Update on the (Name of IPT)

1. ISSUE: Provide a brief background and description of the IPT requirement.

2. FACTS:

- a. Ensure smooth, logical flow of facts.
- b. Describe the potential impact of the issues (Clinical, financial, human resources).
- c. Papers should not exceed two pages in length and need not be signed, but must include the IPT member's name and telephone number in the lower right corner. Include an approval line below the IPT member's name to indicate appropriate approval.
- d. Describe significant timeline issues and decision points. Attach a copy of the current milestone chart.
- e. Describe other Service positions, HA/TMA positions, and other interested parties (i.e., Congress) positions as appropriate.
- f. If approved, state the (Service) position.
- g. The IPT information paper is submitted within 24 hours after each IPT meeting or as a minimum updated the 1st of every month or more often as determined by decision points. Submit information papers to The Surgeon General through the appropriate Assistant Surgeon General and Deputy

MEMORANDUM FOR DIRECTOR, ACQUISITION MANAGEMENT & SUPPORT
DIRECTOR, COMMUNICATIONS & CUSTOMER
SERVICE
DIRECTOR, HEALTH PROGRAM ANALYSIS &
EVALUATION
DIRECTOR, INFORMATION MANAGEMENT,
TECHNOLOGY & REENGINEERING
DIRECTOR, OPTIMIZATION & INTEGRATION
DIRECTOR, PROGRAM OPERATIONS
DIRECTOR, RESOURCE MANAGEMENT

SUBJECT: Appointment of Integrated Project Team Representative for <name of
project>

Your support is requested in the development and implementation of deliverables
for the <name of project>. This team will <Insert statement on purpose of project>.

As the TRICARE Program Executive Officer, I have directed the formation of an
IPT to be comprised of representatives from the Services and functional areas within the
TRICARE Management Activity (TMA). The IPT shall work collaboratively to address
all issues regarding <name of project>.

I request that you appoint an individual from your directorate to serve on this IPT.
The individual should have the requisite authority and expertise to speak for your
functional or operational area considering the project's scope. If you feel that a full time
IPT representative from your Directorate is not necessary, please provide a point of
contact to attend IPT meetings on an as needed basis. If you have any issues or concerns,
which should be, addressed by the IPT, please contact the Project Manager, <name of
PM>. The IPT begins <Month & Year>, and expires upon <identification of
deliverables – Project end>, anticipated <timeframe>. The length of the IPT is estimated
to extend approximately <months>. It is desired for continuity purposes that the person
appointed be able to serve throughout the development and implementation of the
improved processes.

In your appointment memorandum, please use language that clearly describes the
authority and limitations of authority that the appointed IPT member possesses. Please
submit a copy of your appointment memorandum to me within two weeks from the date
of this memorandum. If you have any questions, please contact <PM, name of project>,
at <telephone number and email>.

Appendix A-3:
Lead Agent Representative
Integrated Project Team
Appointment Letter

MEMORANDUM FOR TRICARE LEAD AGENT

SUBJECT: Request for Appointment of Integrated Project Team Representative for the
 <Name of project>

Your participation is requested in developing the TRICARE Management Activity (TMA), <Name of project> Integrated Project Team (IPT). The project will <Insert statement on purpose of project>.

As the TRICARE Program Executive Officer, I have directed the formation of an IPT comprised of representatives from the Services and functional areas within TMA. The IPT shall work collaboratively to address all issues regarding requirement development of the project.

I would like to request that you appoint an individual from your regional office to serve on this IPT. The individual should have the requisite knowledge and expertise to address the development and implementation of the functional and operational requirements needed to carry out this project. The IPT begins <Month & Year>, and expires at the <time project End solution>. The duration of the IPT is estimated to be approximately <months>. It is desired for continuity purposes that the person appointed be able to serve throughout the development of the project.

I have attached a sample of an appointment memorandum for your guidance. The appointment memorandum should clearly state the expectations, responsibilities and authority of your representative. Please forward a copy of your appointment memorandum to me within two weeks from the date of this memorandum. If you have any questions, please contact <PM name> Project Manager, <project name >, at <telephone number> or by email at <PM email>.

Leonard M. Randolph, Jr.
Major General, USAF, MC
TRICARE Program Executive Officer

Attachment:
Sample IPT Appointment Memorandum

SAMPLE

MEMORANDUM FOR (FILL IN)

SUBJECT: Expectations and Responsibilities of Integrated Project Team Members

I have nominated you to serve as the Lead Agent representative on the (Fill-in) Integrated Project Team (IPT) that has been formed by the TRICARE Program Executive Officer under the supervision of the Program Management Directorate, TRICARE Management Activity (TMA). This appointment identifies you as a functional expert on the matters the IPT is addressing.

The purpose of this memorandum is to let you know my expectations of you as an IPT member. First, I expect you to provide the IPT your well thought out functional opinions of the issues. Second, you are the Lead Agent action officer for the issues of the IPT you support. I expect you to fully staff this action. You are responsible for keeping the appropriate staff members informed of the IPT's progress and potential impacts. Coordination will prevent surprise when HA/TMA publishes a policy or begins a project related to your IPT. Finally, you are responsible for keeping me and your supervisor informed on the status of your IPT by reporting to me through your appropriate chain of command using enclosure (1). Accomplishing this process in a timely manner will speed formal HA/TMA staffing within our department.

1. There is a limitation concerning your role as an IPT member. The Project Manager may interpret your opinions to be the Lead Agent position on a particular issue. The limitation is that your opinions are functional ones until the Lead Agent leadership approves a position. You must anticipate the requirement for the Lead Agent position and act to ensure a timely decision.
2. Your role in this process of managing complex and dynamic issues is very important. I look forward to seeing your work on these significant issues. Any questions you have regarding your responsibilities or limitation should be addressed to (fill in) who may be reached at (telephone number) or email:

The Lead Agent

SAMPLE

INFORMATION PAPER

Code
Date

SUBJECT: To Provide a Status Update on the (Name of IPT)

4. ISSUE: Provide a brief background and description of the IPT requirement.

5. FACTS:

- a. Ensure smooth, logical flow of facts.
- b. Describe the potential impact of the issues (Clinical, financial, human resources).
- c. Papers should not exceed two pages in length and need not be signed, but must include the IPT member's name and telephone number in the lower right corner. Include an approval line below the IPT member's name to indicate appropriate approval.
- d. Describe significant timeline issues and decision points. Attach a copy of the current milestone chart.
- e. Describe other Lead Agent positions, HA/TMA positions, and other interested parties (i.e., Congress) positions as appropriate.
- f. If approved, state the Lead Agent position.
- g. The IPT information paper is submitted within 24 hours after each IPT meeting or as a minimum updated the 1st of every month or more often as determined by decision points. Submit information papers to the Lead Agent Director through the appropriate lead agent office chain of command.

Appendix B-1:
Mission Needs Statement
Instructional Template

Mission Needs Statement Instructional Template

Note to the Reader

You are encouraged to tailor the template and make additions or subtractions, as your professional judgement deems necessary. Through this activity, keep in mind that this document is central to a successful project and requires thoughtful deliberation, meaningful participation and careful documentation.

While using this template, please be aware that *plain italicized text* indicates instruction, direction, or a suggestion.

Mission Needs Statement
For
< Project Name >

This Mission Needs Statement (MNS) describes the required operational capabilities (mission or purpose) for <project name>. The MNS identifies major project objectives to which the need responds. If the MNS is carefully prepared to address the project’s end result objectives, future decisions concerning milestones, high-level activities and evaluation pieces may be easier to finalize.

This document should be tailored to meet your project’s specific requirements, but should follow the attached guidelines.

This MNS contains the following sections:

1) Background

2) Statement of Need

3) Major Project Objectives

4) Key Constraints (if applicable)

5) Duration of Project

Approval

I. BACKGROUND

In one or two paragraphs, the background section should familiarize the reader with the project’s Department of Defense (DoD) background.

- *How was the project initiated? Was the project Congressionally mandated, approved by the TMA Executive Director, or proposed as an issue that needed to be addressed by way of program management techniques?*

TRICARE Deputy Executive Director (DED), will determine a suitable methodology to facilitate the interface of the Personnel and Medical communities.

II. STATEMENT OF NEED

The statement of need should clearly explain the project's mission need and operational requirements (where necessary).

C. MAJOR PROJECT OBJECTIVES

This portion of the mission needs statement should establish the main focus of the IPT and clearly state the end vision without presupposing a specific solution.

- *What are the major objectives and desired outcomes of this IPT?*
- *What benefit or need will these objectives be satisfying?*

D. KEY CONSTRAINTS (if applicable)

This section describes any key boundaries or conditions related to the project that may impact satisfying its mission. It is important to identify potential problems that might impede the effectiveness or success of the project. For example:

The MCS contracts are being renewed in many of the regions. Any policy or requirements that are made within the course of the Enrollment IPT Charter must take this into consideration and evaluate the timing of the potential changes, weighing the benefits with the impact that it may have on the contracts that are currently in place at each of the regions.

C. DURATION

In one paragraph, briefly state how long the project will last. The proposed end date from the project charter should be included, as well as any exit criteria or major deliverables that would signify completion of this project.

III. APPROVALS

Delete signature blocks that are not applicable.

Appendix B-2:
Program Management Office
Business Plan
Instructional Template

Program Management Office
Business Plan
Instructional Template

Note to the Reader

You are encouraged to tailor the template and make additions or subtractions, as your professional judgement deems necessary. Through this activity, keep in mind that this document is central to a successful project and requires thoughtful deliberation, meaningful participation and careful documentation.

While using this template, please be aware that *plain italicized text* indicates instruction, direction, or a suggestion.

**Program Management Office
Business Plan
For
<insert IPT name>**

Project Manager's Name
Title
Email address
Phone number

**Program Management Office
Business Plan
For
< *Project Name* >**

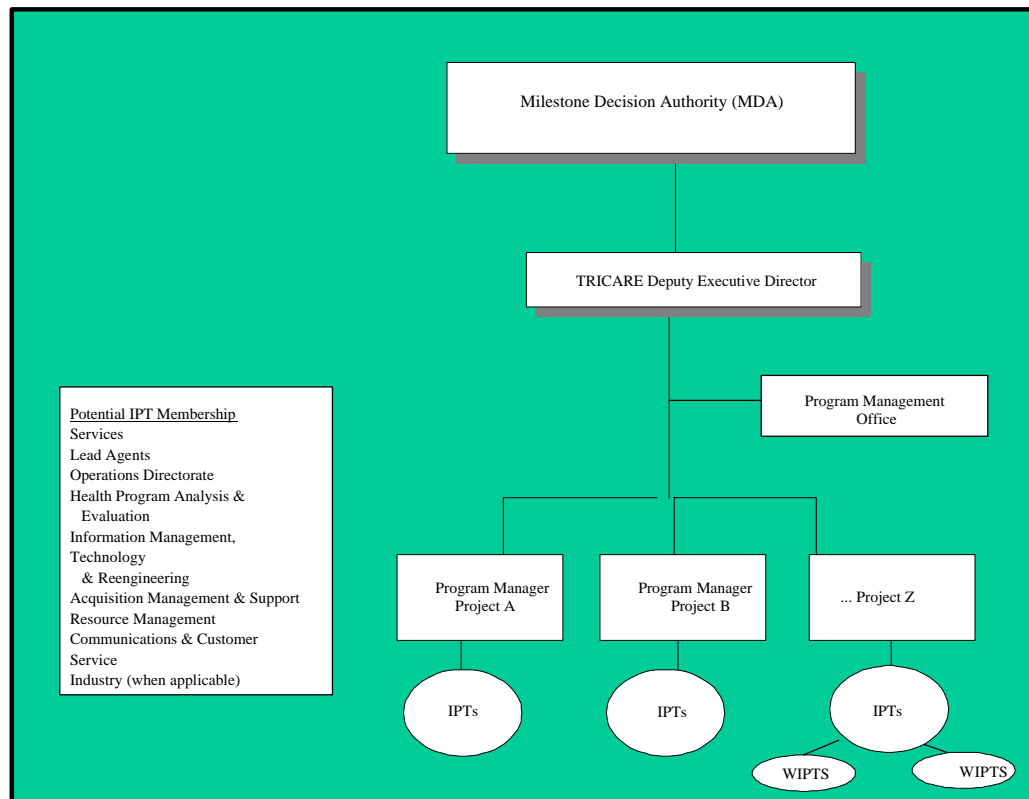
This Program Management Office (PMO) Business Plan presents the processes by which
<*project name*> shall be managed. This document's components include:

- 2) Participants' Roles and Responsibilities
- 3) Business Rules
 - Participation
 - Flow of Activity
 - Communication Protocol
- 3) Relationship between the PMO and Program Management Activities

Organizational Responsibilities and Relationships

The chart below (Figure 1.0) depicts the decision-making hierarchy and the relationship between the TRICARE Program and the projects. The roles and responsibilities of participants and organizations are detailed after the chart.

Figure 1.0
TRICARE Program Management Oversight



Once the overall direction and milestones are established by the Milestone Decision Authority (MDA), execution of the TRICARE Program operates as a “bottom up” activity – all execution decisions are made at the lowest appropriate level possible. Issues that cannot be resolved are elevated to the next level within the organization through completion. Ultimately, the MDA has the final decision authority for the TRICARE Program.

The titles and respective responsibilities are listed below:

Milestone Decision Authority (MDA)	The <i>TRICARE Milestone Decision Authority (MDA)</i> is the final authority for all TRICARE related activities. The MDA approves the advancement of a project from one phase to another. The MDA provides direction, oversight and final approval to all projects.
---	--

Deputy Surgeons General (DSGs)	The <i>Deputy Surgeons General (DSGs)</i> serve as a first level advisory committee and review projects and timelines as presented by Project Managers. The DSGs also provide input from the Service perspective through the nomination of Service representatives and participants.
---------------------------------------	---

TRICARE Deputy Executive Director (DED)	The <i>TRICARE Deputy Executive Director (DED)</i> is primarily responsible for oversight and management of the planning, integration, and coordination of one multiple projects that fall under TRICARE Program Management. Depending upon scope and complexity, projects may be assigned to full-time PMs by the TRICARE DED. The TRICARE DED is accountable to the MDA for delivering a quality deliverable project on schedule and within cost. He/she reports progress and issues regularly to the MDA. The DED determines which programs/projects will require oversight and assignment under Program Management.
--	--

Resource Management Steering Committee (RMSC)	The <i>TRICARE Resource Management Steering Committee (RMSC)</i> membership includes Senior Comptrollers from each Service component served by the Defense Health Program (DHP). The TMA Deputy Director for Resource Management chairs the committee. In coordination with the Health Services Delivery Steering Group, the RMSC makes project funding recommendations. The group also reviews cost estimates submitted with change packages.
--	---

Health Services Delivery Steering Group (HSDSG)	The <i>Health Services Delivery Steering Group (HSDSG)</i> is comprised of senior representatives from each of the Services and TMA Chief of Staff.
--	--

Managers from their directorates and are responsible for knowing IPT progress through reports from their respective PMs and IPT members. All TMA Directors track progress, milestone achievement and provide guidance to the Project Managers.

Program Management Office (PMO)	The <i>Program Management Office (PMO)</i> provides an approved program management model for TRICARE and adds structure and processes, where appropriate, to meet the execution and integration requirements of projects assigned to TRICARE PMO. The PMO process was established to develop a centralized business approach using broad concepts from the DoD 5000 series tailored for the TRICARE Program. This office provides staff support to facilitate issue resolution, monitor project development, and track timelines/milestones. Reports and updates are provided on a routine basis to the TRICARE DED to obtain concurrence. When appropriate, the PMO staff facilitates the integration of PMO projects to ensure all aspects of TRICARE projects are supportive and complementary.
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Project Manager (PM)	The <i>Project Manager (PM)</i> is appointed in writing by the DED. The PM/ is responsible for the planning, integration, management and execution of day-to-day activities associated with meeting the project mission, schedule, cost, and deliverables. He/She is ultimately responsible for the completion of mandatory and discretionary documents and activities, and reports project progress to the DED on a regular basis. The PM coordinates issue resolution through the Integrated Project Team appointed to the project. The PM determines the team composition, meeting frequency and strategic direction. Consultation with the Director, PMO is available as needed.
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Project Coordinator (PC)	The <i>Project Coordinator (PC)</i> is assigned to a particular project by the Program Management Office. The PC is responsible for providing quality program management support by assisting the PM with the activities, issues, decision-making, communications, reporting and overall management of the Integrated Project Team. The PC provides analytical, technical, and logistical support by documenting and tracking project activities, deliverables and briefing schedules. The PC consults with the PM on a regular basis to assist with the program's day-to-day activities. PC support functions cease when Integrated Project Team work is completed.
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IPT consists of senior staff officers within the TMA Directorates, Services, and Lead Agent Offices and other organizations as identified by the PM.

Working Integrated Project Team (WIPT)	The <i>Working Integrated Project Team (WIPT)</i> is responsible for specific issue resolution as assigned by the PM. Potential issues are forwarded to the PM for dissemination to the WIPT chair. WIPTs are appointed and empowered by their work area and participate in resolving specific issues related to the PMO project. WIPTs may work a specific issue for the IPT and present a recommended solution and/or alternatives for IPT consideration and action. Informal WIPTs meet to work a specific issue and present a deliverable to the IPT Chair. This deliverable may be a recommendation to the group, a review of a policy or report, or other short-term task
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Formal Working Integrated Project Team (WIPT)	The <i>Formal Working Integrated Project Team (WIPT)</i> is similar to an IPT in that the formal WIPT scope, length, and mission is approved by the TMA Directors and Deputy Executive Director, and a WIPT Project Officer (PO) is formally appointed. The PO requests membership nominations from Services, TMA, and/or external organizations (as necessary), facilitates teamwork and collaborative decision making regarding WIPT objectives, prepares core program management documentation, and provides leadership briefs at milestone decisions. A formal WIPT and an IPT differ in that a formal WIPT is a subordinate group to a pre-existing or Overarching IPT (OIPT) under leadership of the IPT Project Manager (PM) due to integration of multiple, related missions or the dependency of objectives and deliverables. In the absence of the need for an Overarching IPT, this group would be defined as an IPT due to its scope. The WIPT PO coordinates and informs the IPT PM the forward progress of clearly defined WIPT deliverables/objectives.
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Services Medical Departments and TRICARE Regional Directors	The <i>Services Medical Departments and TRICARE Regional Directors</i> are responsible for providing qualified, empowered staff to participate in the TRICARE PMO project as IPT or WIPT members. As team members, this staff may be asked to determine joint requirements, provide schedules and project deliverables, facilitate various sub-projects, and evaluate or provide comments on projects at various stages of delivery. These representatives are expected to serve as
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In describing your IPT composition, include the specific roles and functions of each IPT member as it pertains to your project.

Example:

The Enrollment IPT will consist of two members from the HPA&E Directorate. One HPA&E member is a Deputy PM for another IPT whose mission is directly impacted by the actions of the Enrollment IPT. This individual will act as the integration nexus and coordinate information between these two IPTs to ensure consistency and non-duplicity of effort. The other HPA&E member has performed extensive site studies on enrollment thresholds in given catchment areas and is most capable in developing metrics and measuring the performance of the initiatives enacted by the Enrollment IPT.

WORKING INTEGRATED PROJECT TEAMS (WIPTS)

WIPTs are working teams represented by cross-functional disciplines. IPTs form a WIPT to analyze a specific issue and recommend potential solutions when input from more than one organization or functional discipline is needed. The director or head of each agency or operation will typically appoint WIPT members. WIPTs should be formed to address a single issue and work on the issue for a shorter time period than an IPT.

There may be many WIPTs formed for a single project to address diverse issues. For example, when a new release of a managed care contract incorporates new information system requirements, the IPT may assign a WIPT to develop the cost estimate of the new requirement. A WIPT comprised of representatives from the Operations Directorate and the Information Management, Technology and Reengineering Office would work to define the functional requirements, develop a feasible technical solution, and develop a cost estimate.

Discuss how this project will employ WIPTs. What groups will be represented? Will there be more than one? Will you use existing groups? Will you establish WIPTs by functional assignments (e.g., Acquisition WIPT, Finance WIPT) or by a specific deliverable or task (e.g., Develop Statement of Objectives)? Who will be on these WIPTs, and why is their representation needed?

II. BUSINESS RULES

D. PARTICIPATION

All Government and TMA support contractor participants must execute a Confidentiality Statement (CS) prior to receiving any project management sensitive information. Integrated Project Team (IPT) members not privy to project management sensitive information are not required to sign the document. They must, however, receive a CS and acknowledge that they understand and will comply with the stated requirements. All new participants will be directed to the Project Manager (PM) who will issue the CS. The original is kept by the PM, who will maintain the list of authorized participants.

Procurement sensitive documents will be provided on a need to know basis only. Procedures to protect this information must be observed at all times. Prior to all meetings, attendees will be screened against the list of authorized participants. In the event a participant does not abide by the stated requirements, the PM may remove that individual from this project.

Depending on the scope of the project, a Co-Project Manager or Deputy Project Manager may be assigned to provide additional management support. In this instance, the manager may delegate confidentiality documentation duties to the Co-Project Manager or Deputy Project Manager (if applicable).

Attendance at IPT meetings is normally limited to IPT members and those directly invited by the PM. Attendance at Working Integrated Project Team (WIPT) meetings is limited to WIPT members and direct invitations from the WIPT chair.

There may be meetings with participation from other areas within the TRICARE Management Activity; core PMO staff that may consist of Government, military, and/or contractors; staff from the Surgeons General offices, or other designated offices. The PM may invite the individual(s) to attend specific meetings. The PM will be responsible for ensuring the invited personnel are instructed on the TRICARE PMO business rules regarding project sensitive information, if applicable. IPT members may also recommend to the PM that an individual or group attend a meeting(s) to assist in issue resolution.

IPT members should identify an individual from their workspace to serve as an alternate IPT member for those meetings they cannot attend. While alternate IPT members will

All items, e.g., contracts requirements, documents, questions, comments, information requests and issues, concerning the various areas that comprise a specific program's management plan or regarding the status of the project will be initially directed to the PM unless otherwise delegated by the PM to a designated IPT member. With the assistance of the PC, the PM will keep a log detailing the information source, date received, date resolved, action officer (an individual, IPT, or WIPT), status and disposition. The PM will not release any information regarding the *<project name>* to unauthorized participants unless a need to know exists.

F. COMMUNICATION PROTOCOL (FOR PROCUREMENT SENSITIVE INFORMATION ONLY)

E-mail communication within the Health Affairs/TRICARE Management Activity (HA/TMA) Network is secure for sensitive information and authorized provided that:

- The e-mail has "Procurement Sensitive" legibly printed at the top and bottom of the communication;
- All recipients have a need to know and have agreed to the terms of the Confidentiality Statement (CS);
- No recipient is located outside of the TMA Local Area Network (LAN);

The transfer of documents and files sent to authorized participants outside of the HA/TMA network must be accomplished using traditional safeguarding measures such as approved Courier Services (i.e., Federal Express) unless a secure email communication channel with encryption has by approved by the PM.

Any questions regarding these procedures should be forwarded to the PM who will resolve the issue.

III. RELATIONSHIP BETWEEN PMO AND PROGRAM MANAGEMENT ACTIVITIES

Program Management activities will be coordinated by the PC to ensure the successful completion of all initiatives identified for management and oversight by PMO. PC coordination of project management activities will eliminate duplication of effort among multiple activities, share information, integrate Program Management projects and secure the efficient production of identified deliverables. All activities will use a teamwork

IV. APPROVALS:

Delete signature blocks that are not applicable

<Insert Name > Co/Deputy Project Manager (if applicable)	Date
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<Insert Name> Project Manager	Date
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Leonard M. Randolph, Jr., Major General, USAF, MC TRICARE Deputy Executive Director	Date
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Appendix B-3:
Project Management Plan
Instructional Template

Project Management Plan

Instructional Template

Note to the Reader

You are encouraged to tailor the template and make additions or subtractions, as your professional judgement deems necessary. Through this activity, keep in mind that this document is central to a successful project and requires thoughtful deliberation, meaningful participation and careful documentation.

While using this template, please be aware that *plain*, *Italicized text* indicates instruction, direction, or a suggestion.

I. OVERVIEW

This Project Management Plan (PMP) provides a roadmap for developing and executing the <project name> Project. It addresses the strategies, roles, responsibilities, plans, milestones, and issues appropriate to the project office's management activities, and it identifies the impact of the project on the TRICARE Program.

Are there any unique characteristics about your project that you would like to highlight?

II. OBJECTIVE

Define the overall project objective. This can be a one or two sentence description of your projects overall mission.

III. SCOPE

Describe, in general terms, the project scope, i.e. the boundaries of the project. For example, is the project limited to an MTF, is it DoD/MHS-wide or is it interagency. Also, list the names of other projects that may be impacted by this project.

Information for the objective and scope should be consistent with what is found in the Mission Needs Statement for this project

IV. PROJECT STRATEGY

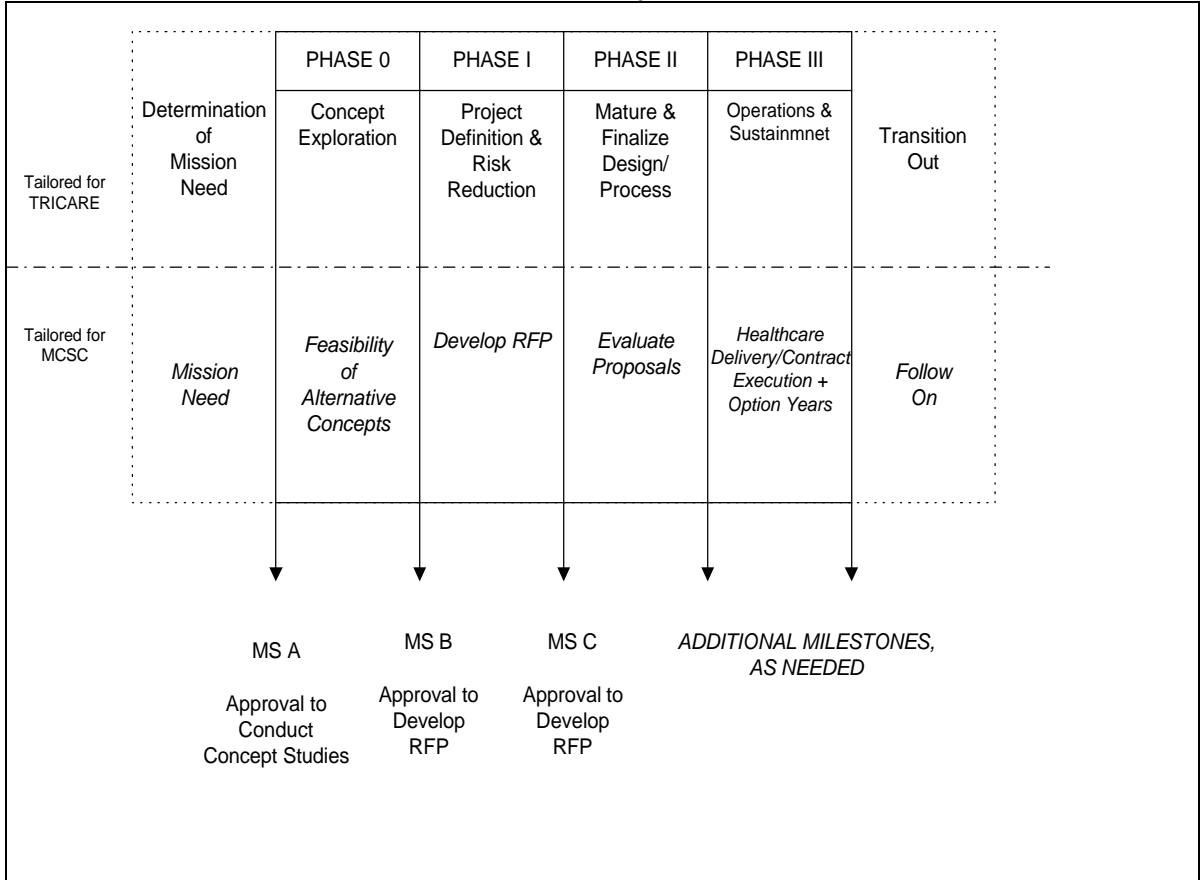
The major activities of the Project will be implemented in a series of four phases:

- Phase 0 Concept Exploration
- Phase I Project Definition and Risk Reduction
- Phase II Mature and Finalize Design and Processes
- Phase III Operations and Sustainment

Figure 1.0, Project Milestones, illustrates the “cradle to grave” concept of milestones and the tailoring of DoD 5000.

The phases and milestones of a Managed Care Support (MCS) Project are included to

Figure 6
Tailoring the DoD 5000 Managed Care Support
Contract (MCSC) Project



The strategies, plans and activities required to establish the project will be consistent with the overall TRICARE Program goals and guiding principles, as detailed in the TRICARE Program Management Office Users’ Guide.

- *In which phase are you beginning the project?*
- *Will your project proceed through all of the phases?*
- *How will you tailor the DoD 5000 phases to meet the needs of your project?*
- *What are the major milestones for your project?*

A. MANAGEMENT APPROACH

phases separated by major decision points called milestones. The process begins with the identification of broadly stated mission needs and translates those needs into a stable, affordable, well-managed project.

At project initiation and after approval of the mission need, the Project Manager (PM) will propose for consideration to the DED/MDA: the appropriate milestones, the level of decision making for each milestone and the documentation for each. Changes and recommendations will be coordinated among the DED/MDA, the Director of PMO, and the Project Manager and subsequently incorporated into the Project Management Plan (PMP). This plan will be submitted to the DED/MDA for final approval.

In addition to this structured, yet tailored approach, key tenets of the DoD 5000.2-R acquisition management model will be used to integrate essential cross-functional disciplines to optimize project decisions. The cross-functional IPT stakeholders will execute the project. When possible, the IPT will use a consensus decision making process.

B. MIGRATION STRATEGY (if applicable)

- *Has this requirement been provided in another capacity?*
- *If so, how will you transition implementation to the new design?*
- *Will there be impacts on current systems, procedures, policies, etc.?*

If the requirement met by the project is currently being provided, describe the process necessary to migrate to the new solution. Identify elements that will be affected by this change (such as information systems). Describe how you plan to move the requirement from the old to the new process.

If this is a brand new requirement, not being fulfilled by any other mechanism, this section is not applicable.

C. ACQUISITION STRATEGY (if applicable)

The following questions should be considered when developing this portion of the Project Management Plan. Keep in mind that this is not a detailed Acquisition Plan. An Acquisition Plan may be necessary; however, it will be detailed later. This section is meant to be the overarching strategy. The following questions may prove useful in getting started.

- *Who will prepare the Acquisition Plan?*
- *Will an Acquisition WIPT be established for other activities? If so, who is required to participate as a member?*
- *Are there legal issues that need to be resolved?*
- *Is the value of the work large enough to require formal source selection procedures?*

D. PROJECT INTEGRATION

The Program Management Office is responsible for compiling and analyzing information from all of the TRICARE Programs. PMO will build and maintain systems that will store all documents, schedules and data for all projects, enabling the TRICARE DED and Director, PMO to:

- Identify opportunities for project collaboration when desirable;
- Identify the program’s impact on TRICARE; and
- Identify the program’s impact on the overall TRICARE Program.

The Director reports regularly to the TRICARE PM on the interrelationships, schedule conflicts, project status, etc.

If you know of any existing integration, please provide a list and description of how your project will affect/depend upon/interact with, etc. the other projects. The tools that are used for integration, such as Primavera and the Integration House, should also be mentioned.

V. DATA STANDARDS

The following questions should be used as a starting point to document this section:

- *Will the project impact any existing information systems, e.g., CHCS, DEERS?*
- *Will the project require a new information system?*
- *Are there any Health Insurance Portability & Accountability Act (HIPAA) standards that apply to my project?*
- *Will any data be considered confidential? Classified?*
- *Are there any special reporting requirements, e.g., GAO?*
- *Have you coordinated new technical requirements with the Functional Integrated*

(threshold) required to satisfy the mission need. Objectives for each performance parameter should represent a measurable, beneficial increase in capacity or operations and support, above the threshold value. The timing of requirements should specify the time-based nature of the need and any events that are driving the need.

- *What means will be employed to measure the success of your project? What are your project metrics?*
- *Are there standards to which the project must adhere?*

Key Performance Parameters (KPPs) are system capabilities or characteristics considered essential for successful mission accomplishment. Failure to meet KPP thresholds may cause the project to be reevaluated or terminated. Below are steps to one methodology for developing KPPs:

- *List required capabilities for satisfying the mission need;*
- *Prioritize these requirements;*
- *For each function, build one measurable performance parameter;*
- *Determine the parameters most critical to project success and designate as the KPP.*

VII. SCHEDULE OF ACTIVITIES

Insert a schedule that identifies high level tasks to be completed. Also identify the major milestones, as well as the exit criteria for each milestone. Information in this section should complement the project Milestone Chart.

VIII. RESOURCE REQUIREMENTS (if known)

A. LABOR

List the labor requirements to complete each phase of the project. Provide information in hours, person years, or full-time employees (FTEs) and break out by labor category such as senior project analyst, clinician, data processor, etc.

- *Is special assistance needed during the PMO process, e.g. business case analysis,*

- Have appropriate documents, e.g. POM Fact Sheets, Form 789, been submitted for action?

IX. RISK ASSESSMENT

A. TECHNICAL RISKS

Identify technical risks associated with incorporating the Project into the overall TRICARE Program. These risks may include the technologies necessary to incorporate the project into the Information Systems currently in place. This section should also address risk mitigation efforts that will be undertaken. Typical technical risk mitigation actions may include system change reviews and analysis. Other technical risks may involve aligning Managed Care Support Contractors' business practices and contracts with the new requirement.

B. PROGRAMMATIC RISKS

Identify the risks associated with obtaining and using resources, including personnel resources and funding resources, to support activities under the control of the PM. Include the subsequent risk mitigation efforts.

1. Cost Risks

Identify the cost risks related to instability in project growth, programmed funding cycles, and costs driven by the marketplace. Potential mitigation strategies include cost and budget metrics, requirements, stability and growth metrics, realistic cost estimations, and routine analysis of the marketplace influences on the program's progress.

2. Schedule/Performance Risks

Identify schedule risks associated with schedule slippage within the project life cycle and in related projects. Mitigation strategies include schedule metrics, use of incremental development and delivery activities, and application of realistic estimation processes for planning project activity. Performance risks include those associated with the contractor performance and the ability to meet the performance expectations or the project requirements. Contractor Performance/Client Satisfaction involves client support, performance, and reliability.

X. APPROVALS:

Delete signature blocks that are not applicable.

<i>Insert Name</i>	
Co/Deputy Project Manager (if applicable)	Date

<i>Insert Name</i>	
Project Manager	Date

Leonard M. Randolph, Jr., Major General, USAF, MC	Date
TRICARE Deputy Executive Director	

Appendix C:
Alpha Contracting

I. WHAT IS ALPHA CONTRACTING?

Alpha contracting is a transition from a consecutive contracting process to a concurrent contracting process. A team approach is used to definitize requirements, develop a rough order of magnitude (ROM) and then negotiate the final contract. The primary advantage of alpha contracting is a shorter timeframe for contract award. The contractor is involved early in the process and participates in the roundtable discussions on project requirements. Far fewer revisions and lags between revisions are required.

A major paradigm shift for TMA will be making bilateral supplemental agreements rather than unilateral changes the standard business practice. This shift will entail a more costly and labor intensive process on the front end due to travel requirements and the heavy focus on joint negotiation sessions; however, the improvement in communications and the overall streamlined process will outweigh these drawbacks.

The alpha contracting team, referred to as the pricing IPT, will work together to define the scope and price of the work and prepare the contract modification. The pricing IPT membership and responsibilities are outlined in the table below.

PRICING INTEGRATED PROJECT TEAM (IPT)	
Project Manager (PM)	Ultimately responsible for ensuring contract modifications adhere to project requirements.
Contracting Officer (CO)	Acts as lead government contracting representative.
Pricing Analyst	Assists IPT in evaluation of proposal.
Change Cycle Manager	Facilitates the pricing IPT to ensure reasonable timetable maintained.
Defense Contract Audit Agency (DCAA)	Advises IPT on government contracting guidelines and constraints, as needed.
Office of General Counsel (OGC)	Advises IPT on legal ramifications, as requested.
Lead Agent (LA)	Provides direct care and MTF specific perspective
Technical Representative(s)	Consult the IPT regarding technical specifications of contract change. Could include independent estimators or government Contracting Officer Representatives (COR's).

II. Alpha Contracting Process

The alpha contracting process begins after the Change Management Board (CMB) approves the change request for implementation. The previously developed joint rough order of magnitude (JROM) forms the basis of the process.

1. Change Cycle Manager and CO receives the approved change package and funding documents (DD789).
2. Timelines set with the MCSC(s) and Pricing IPT.
3. Request for Proposal (RFP) issued.
4. Technical review.
5. On-site fact finding. (Documentation of activities becomes a part of the proposal.)
6. CO and team begin negotiations with MCSC(s).
7. Post-Negotiation Memorandum (PNM) finalized.
8. CO presents to Contract Management Board of Review, if required.
9. Submission to Office of General Counsel (OGC) for legal review.
10. Supplemental Agreement

III. Characteristics for Successful Alpha Contracting

- Commitment to the process.
- Involvement of all parties from the start.
- Combined technical and contracting functions resulting in a seamless process.
- Dissection of the total effort into workable & understandable pieces.
- Willingness of the government and contractors to challenge existing processes and strive for changes.

Appendix D:
Change Management
Frequently Asked Questions

CHANGE MANAGEMENT
Frequently Asked Questions (FAQs)

Q. How do I get on the agenda to brief the various approving bodies, e.g. Change Management Board (CMB), Health Services Delivery Steering Group (HSDSG)?

A. Contact the Program Management & Integration (PM&I) Office to schedule a briefing. They facilitate the change management process and will schedule the appropriate brief. They will also advise you on briefing content, structure and format.

Q. After my change package is approved by the Change Management Board (CMB) how do I request the release of funds?

A. A copy of the minutes from each Change Management Board (CMB) meeting is forwarded to the Resource Management (RM) Directorate who then processes Form 789. This form is forwarded to Contract Management and authorizes them to begin work on the change request.

Q. How do I request participation from the managed care support contractors (MCSC)?

A. Work through the Contracting Officer (CO) in Aurora assigned by the Acquisition Management and Support (AM&S) Directorate to your project for managed care support contractor (MCSC) participation. The CO is the only government personnel authorized to contact the MCSC.

Q. Where do I get Project Fact Sheets?

A. Project Fact Sheet templates can be downloaded from the TRICARE website <http://www.tricare/pmo/info/templates.html>.

Q. What is an independent cost estimate and how do I request one?

A. An independent cost estimate is a cost estimate provided by any source other

Q. What is a contractor Rough Order of Magnitude (ROM) and how do I develop one?

A. A contractor rough order of magnitude is a cost estimate developed with participation from the government and the managed care support contractor (MCSC). Begin by forming an integrated project team (IPT) to develop a framework or draft of your project requirements. Contact the Contracting Officer (CO) for your project when you are ready to bring the MCSC into your meetings. Although cost estimates obtained at the end of the process should be very close to actual, keep in mind that the objective of the ROM process is to gain agreement on project requirements not to negotiate price.

Q. What is the difference between a Rough Order of Magnitude (ROM) and a contractor Rough Order of Magnitude (ROM)?

A. A rough order of magnitude (ROM) is developed for concept approval. It is a very rough cost estimate and does not necessarily include input from a formalized integrated project team (IPT) or the managed care support contractor (MCSC). A contractor ROM is a far more accurate cost estimate formulated in cooperation with an IPT and the MCSC.

Q. How do I formulate a cost estimate for my project?

A. A contractor rough order of magnitude (ROM) and independent contractor cost estimate are two tools to assist the Project Manager in cost estimation. Additionally, contract staff may be consulted.

Q. What if the project's negotiated final cost is significantly higher than the estimate approved by the Change Management Board (CMB)?

A. During all phases of project development close attention must be paid to variances in cost. If the difference between approved Change Management Board (CMB) funding and the contractor's negotiated final cost is greater than 10%, you will be required to go before the CMB to justify the need. Additionally, the Contracting Officer (CO) will advise if negotiations need to be halted due to cost overruns.

Q. My project has been approved by the Change Management Board (CMB)

Q. How is the managed care support contractor (MCSC) reimbursed for contractor rough order of magnitude (ROM) development?

A. A cost reimbursable contract line item (CLIN) has been incorporated into the managed care support contract. Government contracting staff will issue task orders against this CLIN for contractor ROM funding.

Appendix E:
Program Objective Memorandum
Fact Sheet

PROJECT NAME
PROJECT MANAGER (Name, Office Symbol, and Phone)
DATE PREPARED

DESCRIPTION: A brief, one-paragraph description of this project

BENEFICIARIES IMPACTED: (all, AD, ADFM, AD-TPRFM, >65, <65 retirees, etc)

GOVERNING REQUIREMENT DOCUMENT: (Reference Legislation & Section, or other documentation that directs or mandates this project)

IMPLEMENTATION MODE: (Managed Care Support Contract, Other contract (specify), Service Direct Care system (specify if appropriate), combination (if a combination break out at Purchased Care and Direct Care in the cost estimate, etc.)

KEY DATES:

OTHER: Any other information or background that is important to the project

PRICING (\$ in Thous):

	<u>FY01</u>	<u>FY02</u>	<u>Required</u> <u>FY03</u>	<u>FY04</u>	<u>FY05</u>	<u>FY06</u>
<u>FY07</u>						
O&M-MCSC						
O&M-Dir Care						
O&M-IMIT/Other						
O&M Coast Guard						
O&M Other Non-DoD						
Procurement						
RDT&E						

	<u>FY01</u>	<u>FY02</u>	<u>Funded</u> <u>FY03</u>	<u>FY04</u>	<u>FY05</u>	<u>FY06</u>
FY07						

	Requested Adjustment (Required – Funded)					
	<u>FY01</u>	<u>FY02</u>	<u>FY03</u>	<u>FY04</u>	<u>FY05</u>	<u>FY06</u>
<u>FY07</u>						
O&M-MCSC						
O&M-Dir Care						
O&M-IMIT/Other						
O&M Coast Guard						
O&M Other Non-DoD						
Procurement						
RDT&E						

	Recommended Offset					
	<u>FY01</u>	<u>FY02</u>	<u>FY03</u>	<u>FY04</u>	<u>FY05</u>	<u>FY06</u>
Project Title						

Requirement Cost Definition Summary (attach IGCE or other detailed documentation—sub-bullets below must be completed):

<u>MCSC IGCE</u> (\$K)	<u>FY01</u>	<u>FY02</u>	<u>FY03</u>	<u>FY04</u>	<u>FY05</u>	<u>FY06</u>	<u>FY07</u>
---------------------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------

Assumptions

Methodology

Data Source (IGCE, JROM, ROM, Other). For MCSC items—if IGCE is available, but not used in requirement section, quantify and explain the difference between the current estimate (required) and the IGCE.

SERVICE SPLIT RECOMMENDATION: Specific split or recommended methodology for split between Services **must** be provided regardless of mode of implementation (MCSC, MTF, etc).

COST RISKS: Explain factors or possible situations that may invalidate cost estimate.

Project Manager Coordination: _____
(signature and date)

Project Sponsor Coordination: _____
(Service RM, or TMA Director signature and date)

Appendix F:
Integrated Project Team (IPT) Charter
Instructional Template

CHARTER
Military Health System (MHS)
<Name of Project>

1. **Purpose**
Briefly, in one or two sentences, state the purpose for this project being established.
2. **Scope of Activity**
In a few sentences, outline the major focus or activities that this IPT will be working on.
3. **Membership**
Title, Organization / Service, Division/Directorate Chair
Title, Organization / Service, Division/Directorate Member
Title, Organization / Service, Division/Directorate Member
Title, Organization / Service, Division/Directorate Member
Title, Organization / Service, Division/Directorate Member
4. **Meetings**
Describe how meetings will be held, i.e. who hosts them, how often they will take place, etc.
5. **Deliverables**
List the major deliverables that will be generated by this IPT, to include the Core Documents, other supporting documentation, any products that result from this effort, etc. If minutes are produced from IPT meeting and/or WIPT meetings, cite that as well.
6. **Duration**
Cite how long this IPT is going to last, e.g., a certain period of time or at the discretion of the TRICARE Deputy Executive Director. If closure of this IPT is dependent upon a final deliverable, cite the deliverable.

Project Manager _____ Date _____
Insert PM's Name

Appendix G:
Milestone Chart Explanation
and Instructional Template

Explanation of Milestone Template

The milestone chart should be updated monthly and included with information papers and all IPT status briefings.

The following must be added to the chart:

- **Start Date:** this is the date the Project Manager appointment letter was signed
- **Projected End Date:** projected date the program will be implemented or completed
- **Shade the Current Phase:** shade (in gray) the current phase of the project
- **Check Mark Completed Tasks:** put a check mark bullet on the items in the shaded area (current phase) that have been completed
- **Decision Points:** list the items/tasks requiring a decision from leadership/Services. Include a 'no later than' date (NLT MM/YY)
- **Current Issues:** list the current issues that the project is facing. Denote each of the current issues with a

Start Date:
MM/YY



Projected
End Date:
MM/YY



4

Green circle if the issue(s) won't stop the program



Yellow circle if the issue(s) may stop or slow down the program



Red circle if the issue(s) will stop the program if not addressed



